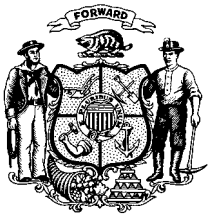
# Wisconsin

# Long Term Care

# Functional Screen

# Instructions




**Department of Health and Family Services**

**Division of Disability and Elder Services**

~~**Center for Delivery Systems Development**~~

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# LTC FS Clinical Instructions

## Module #1: Overview of the Long Term Care Functional Screen (LTC FS)

### Objectives

*By the end of this module you should be able to:*

- Recount the process and major criteria used to develop the LTC FS.
- Explain what the LTC FS is designed to do.
- Explain how the LTC FS is to be administered, by whom, and in what manner.
- Utilize strategies for minimizing identified Screen limitations.
- Accurately document fluctuations in people's abilities and long term care needs.
- Recognize when the services of a medical professional are needed to properly complete the health-related sections of the LTC FS.

## 1.1 History

The Wisconsin Long Term Care Functional Screen (LTC FS) has been under development since 1997. It is a **functional needs assessment describing assistance needed with**:

- **Activities of Daily Living** (ADLs-bathing, dressing, mobility, transfers, eating, toileting)
- **Instrumental Activities of Daily Living** (IADLs-meal preparation, medication management, money management, telephone, transportation, and employment)
- **Health Related Tasks** (including skilled nursing)
- **Diagnoses**
- **Behavioral Symptoms and Cognition**

The LTC FS also includes information on risk factors, mental health and substance abuse, and where the person would like to live.

The LTC FS computer application has complex logics programmed into it that interpret entered data to determine applicant's nursing home level of care, disability level of care, and functional eligibility level for Wisconsin's long term support programs. Family Care pilot counties have been using the LTC FS since 1998. Use of the LTC FS was expanded to Partnership and PACE programs in November of 2001, and is being expanded to other home and community-based waiver programs throughout Wisconsin.

The LTC Functional Screen's eligibility and nursing home level of care logics have been tested for reliability and validity, and approved by the Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration) to replace previous methods of home and community-based waiver eligibility in Wisconsin. The major advantages of the LTC FS are that eligibility determinations are instantaneous upon completion of the LTC FS (e.g., on a laptop in the consumer's home), and reflect an objective method of eligibility determinations.

The WI LTC FS was developed through four workgroups which included county case managers experienced in LTC eligibility and assessments. The primary screen development workgroup reviewed

numerous other screens and assessment such as the Minimum Data Set (MDS) that nursing homes must complete, and the OASIS form that home health agencies must complete.

The WI LTC FS is different from those forms because it had to meet the needs of Wisconsin's LTC redesign effort. In particular, the LTC FS needed to work for all three target groups: frail elders with health conditions or dementia (mild or severe); younger people with physical disabilities, some of whom have no health problems; and people with developmental disabilities with various cognitive functioning levels, behavior symptoms, and/or health problems. The WI LTC FS needed to work to describe people living at home or in substitute care settings (group homes, adult family homes) or in institutions (nursing homes, ICF-MRs). Other criteria used to develop the WI LTC FS include the following:

- Clarity--Definitions and answer choices must be clear to screeners (most of whom are not nurses)
- Objectivity and Reliability--The LTC FS must be as objective as possible to attain highest possible "inter-rater reliability"-i.e., that two screeners would answer the same way for a given consumer. Subjectivity must be minimized to ensure fair and proper eligibility determinations.
- Brevity--The LTC FS is only a "needs assessment" to determine program eligibility. It serves as a baseline for more in-depth assessment to develop a service plan that reflects the consumer's strengths, values, and preferences.
- Inclusiveness--Every individual can be accurately described with given choices for each question--for elders, people with dementia, physical disabilities, or developmental disabilities, healthy or not

Note: For HCBW counties a full assessment and service plan packet must be completed per waiver manuals prior to implementation of the waiver.

## 1.2 The LTC FS Determines Eligibility for Long Term Care Programs

Wisconsin has four waiver programs for the elderly and physically disabled. They are COP/ Waiver, CIP II, Family Care, and the Wisconsin Partnership Program.

Once an applicant's LTC FS is complete, the eligibility logic built into the application is able to determine that person's Nursing Home Level of Care (NH LOC), Developmental Disability Level of Care (DD LOC), and Family Care Level of eligibility (Intermediate or Comprehensive) as well as eligibility for other waiver programs. NH level of care is absolutely necessary to be eligible for COP/W and CIP II because those two programs can only serve NH eligible people. This is also true for the PACE and Partnership programs.

At this time, the LTC FS determines functional eligibility for HCBW programs (including COP Level 3 Alzheimer's/Interdivisional Agreement 1.67), PACE/Partnership, and Family Care for people aged 18 and older.

Wisconsin has the following four levels of **nursing home levels of care**:

1. Intermediate Care Facility, Level 2 (ICF-2)-lowest needs
2. ICF Level 1(ICF-1)-moderate needs
3. Skilled Nursing Facility (SNF)-high needs
4. Intensive Skilled Nursing (ISN)-highest needs

Wisconsin has three waiver programs for people with developmental disabilities. They are CIP 1A, CIP 1B, and Family Care.

Wisconsin has four institutional **levels of care for people with developmental disabilities**:

1. DD1A-DD person with significant medical problems
2. DD1B-DD person with significant behavioral problems

3. DD2-DD person not DD1a or DD1B who needs help with all or most activities of daily living (ADLs) and instrumental activities of daily living (IADLs)
4. DD3-DD person who is more independent with most ADLs and IADLs

Note: Individuals with developmental disabilities who meet certain criteria for no active treatment (NAT) may be placed on a physical disabilities or frail elderly waiver (see 10.10 No Active Treatment).

For Family Care there are 2 levels of eligibility:
1. Comprehensive
2. Intermediate

**NH level of care & HCBW programs**:

Getting a NH level of care means that the person is "nursing home eligible." This in turn means that the person is eligible for home and community-based waiver (HCBW) programs such as COP-W. Getting a DD level of care means that the person is eligible for an ICF-MR and eligible for HCB waiver programs for people with DD (CIP). HCB waiver eligibility is needed for use of the expanded financial eligibility criteria in order for the person to qualify for a Medicaid card. People not eligible for a HCB waiver must be funded solely through state and county funds if they do not qualify for an MA card through the regular Medicaid financial requirements. So HCB waiver eligibility is important in order to both obtain federal funding for LTC services (at a 60% match); and for the person to qualify for a Medicaid card. To summarize:

*NH level of care or DD level of care = NH (or ICF-MR) eligible = HCB Waiver eligible = 60% federal match for state dollars.*

*No NH or DD level of care = not NH (or ICF-MR) eligible = not HCB Waiver eligible = 100% state funds with no federal match for LTC services, if the person is not eligible for regular MA through normal financial criteria.*

If a person does not get a NH or DD level of care, they may still be eligible for COP-Regular (level III of the COP Functional Screen).

The remainder of this section describes NH and DD LOC and how these LOC's interact with Family Care eligibility.

**NH or DD level of care and Family Care**:

NH or DD level of care is very important in Family Care as well. Family Care has as part of its structure, a home and community-based waiver, but because it combines waiver funds with non-waiver state-only funds, it can include some people who are not eligible for a home and community-based waiver--that is, people who do not make NH or DD level of care.

The budget for Family Care is based on the premise that the majority of people served would qualify for a NH or DD level of care, and thus capture the 60% federal match.

Screeners must ensure that NH or DD levels of care are properly determined for every Family Care applicant, in part to ensure that federal Medicaid HCB waiver funds are appropriately obtained.

At this point there are two levels of Family Care eligibility that overlap with HCB waiver eligibility (and thus with NH or DD levels of care). Screeners must understand the ways these different eligibility categories work.

The two levels of Family Care eligibility are "Intermediate" and "Comprehensive" (A third level would be "Not Eligible for Family Care.")

**Family Care Intermediate**: People at the Intermediate level usually need help with only one or a few particular ADLs or IADLs and are not nursing home eligible, thus they are not automatically eligible for Family Care. People at the Intermediate level not eligible for Family Care should be helped by the Resource Center with options counseling. Only those people at the Intermediate level who have a

Medicaid card, are on the “grandfathering” list, or are in need of Adult Protective Services (APS) are entitled to the program. If a person at the Intermediate level is eligible and enrolls into a CMO, the CMO is paid a reduced monthly payment from WI DHFS, with no federal dollars mixed in.

**Family Care Comprehensive**: Family Care Comprehensive level includes all NH eligible people. If someone makes a NH or DD level of care, they are automatically Comprehensive.

*NH level of care or DD level of care = NH eligible = HCB Waiver eligible = Family Care Comprehensive = Higher payment to CMO and = 60% federal match*

Person with a Comprehensive level is entitled to the program, and cannot be put on waiting lists. CMO receives a higher monthly payment from WI DHFS for Comprehensive enrollees.

Family Care Comprehensive level includes a few people who are not NH eligible, but who have very high needs for assistance. For these people, DHFS pays the CMO the higher monthly rate, but because the person is not HCB waiver eligible, there is no federal match funding unless the person has regular Medicaid.

Screeners should always confirm that the NH or DD level of care seems appropriate for the person. If it seems someone should be nursing home eligible, then the LTC FS should assign them a NH level of care. Be sure you confirm all health-related services with a nurse or other health professional familiar with the consumer. Consult with your Screen Lead, who can contact DHFS if necessary.

## 1.3 Other Functions of the LTC FS

1. Serve as a foundation for the comprehensive assessment done by the long term care program selected by the consumer
2. Provide data for quality assurance and improvement studies for the Department of Health and Family Services (DHFS) and long term care programs utilizing the LTC FS, including identifying cases for targeted reviews
3. Identify whether an applicant is currently in need of Adult Protective Services(this factor affects entitlement for persons at Family Care (FC) Intermediate level)
4. Indicate the need for referrals to Adult Protective Services, mental health services, substance abuse services, or other community resources

**For Family Care Counties, the LTC FS also**:

1. Provides a framework for information-gathering during Pre-Admission Counseling
2. Is used to set monthly payment rates based on people's functional needs
3. Documents factors to aid in prioritizing waiting lists

## 1.4 Requirements for Quality Assurance and Screener Qualifications

As discussed above, the Wisconsin Long Term Care Functional Screen (LTC FS) determines a person's eligibility for Wisconsin's long term support programs, including Family Care, PACE and Partnership, and the home and community- based waiver programs. Family Care is an entitlement, so for Family Care counties, the screen determines entitlement to services. **Because the LTC FS determines program eligibility, special requirements for quality assurance and screener qualifications are necessary.**

***Screener Qualifications***

**All persons administering the functional screen must meet the following four conditions:**

1. Meet the following **minimum criteria for education and experience**:
    - Bachelor of Arts or Science degree, preferably in a health or human services related field, and at least one year of experience working with at least one of the target populations; or

- Prior approval from the Department based on a combination of post-secondary education and experience or on a written plan for formal and on-the-job training to develop the required expertise prepared by the agency
- In HCBW counties, people screening DD individuals must be qualified as QMRPs**.

2. Meet all **training requirements** as specified by the Department
   - Completion of the web-based clinical certification course is currently the primary way to meet the Department's training requirements. In specific, all screeners should read screen instructions in their entirety.
3. Have **experience working with long term care consumers**.
4. **Pass all Screener Certification exams** after receiving training. There are eight certification tests that are part of the online course. All eight must be successfully completed (a score of 80% or better) to become a certified LTCFS Screener

**Further, for Family Care, Resource Center and CMO managers and screen leads must:**

- Also see the Resource Center and CMO contract for quality assurance requirements.

*"Qualified Mental Retardation Professional" or QMRP means a person who has specialized training in mental retardation or at least one year of experience treating or working with mentally retarded people and is one of the following:
1. A psychologist licensed under ch. 455, stats
2. A Physician
3. A Social Worker with a bachelor's degree or graduate degree from a school of social accredited or approved by the council on Social Work Education.
4. A physical or Occupational Therapist who meets the requirements of s.HSS 105.27 or 105.28
5. A Speech Pathologist or Audiologist who meets the requirements of s.HSS 105.30 or 105.31
6. A registered nurse
7. A Therapeutic Recreation Specialist who is a graduate of an accredited program who has a bachelor's degree in a specialty area such as art, dance, music, physical education, or recreation therapy; **OR**
8. A Human Service Professional who has a bachelor's degree in a human services field other than those noted under 1-7, such as rehabilitation counseling, special education, or sociology.

## 1.5 Screen Quality

Parallel to the screener qualification, training, and certification requirements stated above, there are quality performance and assurance requirements to ensure consistency and accuracy of administration of the screen. There are three levels of functional screen quality assurance.

1. The first efforts are quality assurance beginning with the screener. **It is the screener's responsibility to be objective in screening, to be informed of the instructions, and to corroborate information gathered from the consumer.** Questions that arise can be addressed by the person in your office designated as Screen Lead.

2. **Among the Screen Lead's roles is to oversee quality assurance**. The methods each agency will be conducting will, at a minimum, include:
   - Inter-rate reliability testing;
   - Training, mentoring, and monitoring new screeners;
   - Random sampling for accuracy and consistency;
   - Completing reports; and
   - Consulting with state staff on consumers.

For the Family Care program the final step in quality assurance occurs at the State. **Staff at the Department of Health and Family Services will review screens and quality assurance methods during annual site visits and quarterly examine a series of analyses and comparisons of all agencies' screens**. Each agency will receive a report following such reviews and request the agency to correct and amend screens done in error.

## 1.6 The LTC FS Is Voluntary

**Consumers must consent to having the LTC FS completed in order to enroll in a long term support program** (COP, Family Care, Partnership). The person being screened should consent to completion of the LTC FS and its submission to DHFS for aggregate data research. No screen should be completed without the person's consent.

Screening agencies shall comply with confidentiality rules and requirements and shall obtain a signed release of information from the person or the person's guardian or power of attorney, where applicable, for the use of medical records, educational records and other records as appropriate before conducting the LTC Functional Screen. Signed releases of information shall be included in the person's records when appropriate.

## 1.7 Confidentiality

**Any information collected for the screen or during the screening process is confidential.** It is to be treated with the same requirements for confidentiality as other long-standing screens and assessments. If a person enrolls in a long term care program (Family Care, Partnership, COP), the functional screen can be shared with that program without separate written permission.

## 1.8 Screening and Re-Screening Requirements

**In the home and community-based waiver programs and the PACE and Partnership programs an initial screen is required to establish eligibility prior to receiving services. An annual screen is required thereafter to ensure continued functional eligibility.**

**In Family Care:**

**County Resource Centers will be the most common place from which long term care consumers can be screened by the LTC FS to determine their functional eligibility for LTC programs.** It should be noted however, that Resource Centers do more than just administering the LTC FS, they are also places where long term care consumers and their families can go for counseling on all long term care options. Resource Centers are responsible for information and assistance, early intervention and prevention, and informing the public about community resources both within the LTC system and beyond it. The multifaceted nature of Resource Centers is beneficial to consumers, since they are able to get information on all long term care options through a single entry point.

In addition to Resource Centers, the LTC FS may be administered by Family Care--Care Management Organizations (CMOs) during "**re-screening**", or other long term care programs that manage their own eligibility and enrollment processes. CMOs should not be involved with doing someone's screen prior to enrollment.

**It is critical that whenever the condition of a person enrolled in a LTC program substantially changes, the LTC FS should be updated and the eligibility logic re-run to determine if the change in condition impacts their NH/DD level of care or Intermediate/Comprehensive eligibility.**

Examples when a re-screen is necessary:

- Larry, an 88-year-old Family Care participant suffers a stroke.
- Mary, a 79-year-old woman regains her mobility after healing from a hip fracture.
- Jose, a 44-year-old man with Downs Syndrome is diagnosed with early on-set dementia.

**It is important that when re-screens are done, that the screener review the person's previously completed screens for information and historical perspective.** The LTC FS can be done more often than yearly if someone requests it.

## 1.9 The Screening Process

**The screening process requires face-to face contact with the individual being screened. No screen should be completed without a meeting with the consumer, even if s/he is unable to communicate.**

***The Interview Process***

The LTC FS was not designed as an interview tool; screeners are expected to use their professional skills to adjust their interview style to the individual and the situation. The screen can be done in any order.

The face-to-face interview can take place in any setting, from the consumer's residence, to a substitute care setting such as a CBRF, to a hospital or nursing home. It may take more than one contact with the consumer to complete the screen.

Screeners should use their professional interviewing skills to gather information in a way that is appropriate for a given consumer. The screener will need to ask questions in a variety of ways, be familiar with the participant target group being interviewed, and use collateral informants as necessary. Collateral informants include family, significant others, formal or informal caregivers, health care providers, and agencies serving the consumer. The screener must always have a face-to-face contact with the consumer, even if other informants are used.

Sometimes answering the Target Group question requires using the same information gathered later within the LTC FS. This is because the statutory definitions of the target groups require significant functional impairments in several areas of living, including ADLs, IADLs, cognition, behavior, etc. Again, screeners are to use professional interviewing skills to determine the person's needs and abilities. In doing so, you will sometimes be answering the Target Group and the ADL/IADL questions at the same time. Follow all instructions and Target Group guidelines closely.

## 1.10 Reliability of Screen and Screeners

This screen has been repeatedly revised with users' input and statistically proven to have acceptable levels of validity and reliability. However, it is generally recognized that any objective rating of consumers' functioning, cognition, behavior and symptoms can be difficult. The difficulty calls for extra vigilance to ensure the greatest possible accuracy in the LTC FS. This is why screeners must be certified and why DHFS and Wisconsin long term care programs must have ongoing quality assurance processes.

**Screeners should adhere to the following guidelines:**

- Read and follow screen definitions and instructions closely
- Go slowly and carefully enough to be accurate even with someone you know well
- Do not “inflate” any answers because you think a consumer has special costs not “visible” through the screen. Instead, you should always select the answer that most accurately describes the consumer's status
- All screening agencies should have experienced LTC FS Screeners to assist you with questions. Refer all questions to your designated Screen Lead Staff. The screen lead in turn will refer unresolved questions to the Department of Health and Family Services as necessary. In this way, interpretations can be kept consistent and communicated to all programs utilizing the LTC FS, and revisions can be made to the LTC FS if necessary.

An applicant's LTC FS will be taken in total. The LTC FS logic has been programmed to “weigh” all clinical factors in ways that reflect likely needs. The Risk section of the LTC FS plays an important role in how a consumer's screen works in total. The Risk section was specifically developed to be able to “capture” people who might be independent in ADLs and IADLs, without any cognitive impairment-but still at risk. So screeners should never “inflate” their answers in other modules to compensate for risk factors; screeners can document risk factors in the Risk section of the LTC FS.

## 1.11 Screening Limitations

In particular, screeners should **be aware of the following limitations found in national studies to be characteristic of all similar screens**:

A. Health care and institutional providers tend to overrate the consumer's dependency on others.
B. Guardians, spouses, and family members often tend to overrate the consumer's dependency on others.
C. Consumers often underrate their need for help from others and exaggerate their abilities.
D. Consumers' functional abilities can fluctuate, making it difficult to select a “best” answer.
E. Consumers can provide conflicting information at different times or to different screeners.
F. Screen answers vary somewhat depending on whether the screener knows the consumer well or not.
G. Screen answers vary somewhat depending on the profession of the screener.
H. While objectivity is the ultimate goal, some subjectivity may remain in some questions.

## 1.12 Strategies to Minimize Screening Limitations

**A and B: Conflicting Information from Different People**

Sometimes screeners will get different information from different sources. Consumers may function less independently in day care facilities or institutions than they do at home, and staff at such facilities may tend to perceive more dependency than family or peers in the community might perceive. Screeners are to use their best professional judgment to describe the person's functional abilities as accurately as possible given all the information from multiple sources. Keeping in mind the tendencies noted above, the best source of information (besides the person themselves) is someone who does a lot of direct care for the person and likes her/him. In a health care facility, the screener should (if collaboration is needed) talk to a nurses' aide, not just the nurses. In the home, a personal care worker might provide a more accurate description than family members.

**C: Consumer Gives Apparently Inaccurate Information**

Sometimes the consumer's statements about her/his abilities do not seem to cohere with reality. If you feel this is happening, follow this three-step process:

1. Seek more details
2. Seek collateral informants, other people you could ask for additional information
3. Use your professional judgment to select what seems to be the most accurate answers. Follow the definitions and instructions for the screen

Remember that the goal is to be as objective as possible, to have high “inter-rater reliability”-meaning that other screeners would choose the same answer you did. That is why your professional judgment must be based on as much objective information as possible. Objective information can be obtained by asking questions, asking for demonstrations, observing evidence carefully. If the proper answer is still not clear, discuss it with your Screen Lead, who can then, if necessary, ask DHFS for guidance.

So, for example, if someone tells you he bathes himself, but he has obviously poor hygiene and he can barely walk and transfer himself, you should follow the three steps above:

1. Seek more details: Ask him how he bathes (bath? shower? sponge bath?). Ask if you can look at his bathroom to check for accessibility and adaptive equipment. Ask him how he gets in and out of his bathtub. If it has high sides, ask him if he can lift his foot that high, and to show you.
2. Seek collateral informants: Ask him if you can talk with his family members. They may have opinions (“He should be in a nursing home”) as well as objective information (“He's really gone downhill since mom died last year, he's fallen at least four times, he can barely move, he hasn't been in that bathtub for months, he won't accept any help from us even when we tell him he needs a bath.”)

3. Use your professional judgment to select the best answer: In this example, it seems he's definitely not independent with bathing. It's not exactly clear whether Bathing Level of Help #1 (helper does not have to be present throughout task) or # 2 (helper does have to be present throughout task) is most accurate. With the history of recent falls and his excessive independence, #2 might more accurately reflect what he really needs at this time.

**D. Abilities Fluctuate**

Some similar screens or data collection instruments like the Minimum Data Set (MDS) required of nursing homes and the OASIS (required of home health agencies) were designed to provide a "snapshot" view of functional status. So their questions ask, for example, for functioning in the past 7 days, or over the past month. The LTC FS provides a broader view to more accurately reflect an individual's likely **long-term care needs**. ~~We realize that many long-term care consumers have conditions and abilities that fluctuate over time, and that it is sometimes difficult to choose the best "multiple choice" answer. In completing the screen, please follow the following guidelines:~~

- ~~If the person's functional abilities vary **over months or years**, select the answer that seems closest to the average frequency of help needed~~
- ~~If the person's functional abilities vary **day to day**, select the answer that most accurately describes their needs on a "bad" day~~
- ~~If the person's functional abilities vary **week to week**, try to select answers that reflect how you would staff them if you had to~~

ADLs and IADLs on the LTC FS are to be checked if the person needs help at least one third of the time. In many cases, a person's need for help is fairly consistent: "She can't do that," or "He always does this," or "Most of the time…" Usually this will reflect the day to day needs of the person.

In other cases, the person's needs arise only some of the time. Very infrequent needs cannot count toward eligibility for long-term care programs. Usually this will reflect variation in abilities over months or years.

When frequency is at question, screeners should use a simple **one-third rule**: If the person has a limitation **one third** of the time (or more often) then it counts as a deficit on the screen. If the person has a limitation less than one third of the time, the ADL/IADL deficit should not be captured. **In general, consider the ADL/IADL function over a six-month timeframe**.

The "one third of the time" criterion does not mean that the screener tests the person or measures their needs or abilities only during the visit to complete the LTC FS. If a person says "now and then," "every few weeks," or "a few times, not mostly," it's probably less than one third of the time. You can even ask the person, "In the past few months, would you say you've needed help more than one third of the time?"

Remember that "help" includes supervision, verbal cueing, and partial or complete hands-on cares.

Example: John has cancer and gets very sick during chemotherapy and he needs help with his ADLs then; at other times he is independent with them. John gets chemotherapy one week each month. Screener does **not** indicate that John needs help with his ADLs because he needs help less than one third of the time – one week out of four.

Example: Mabel is a woman with serious mental illness. Her need for help varies widely as she cycles from depression to manic states. Overall, Mabel needs verbal cueing or supervision at least 10 weeks out of the past six months (sometimes even hands-on help). Mabel needs help more than one third of the time.

## 1.13 Screening During Acute Episodes

An acute episode involves conditions which are expected to resolve in the next few weeks. These types of episodes can occur at home, in the hospital, in a nursing home, or in other locations.

The LTC FS may be completed when consumers enter nursing homes and residential facilities. Approximately 70% of people enter nursing homes from hospitals. It is expected, then, that some LTC FS will reflect higher needs due to more acute conditions and that many people may improve over the next several days, weeks, or months. Their improvement will be evident in their next LTC FS. However, if a person experiences a change in condition likely to affect their eligibility, an “03-Change of Condition” screen should be done.

For Family Care, the LTC FS must be completed by the Resource Center as part of pre-admission counseling when consumers enter nursing homes and residential facilities.

## 1.14 Impending Discharge

**When doing the LTC FS on someone preparing for discharge from a skilled health care facility, complete the screen based on how the person would function at home when they go home.** This looking ahead is a normal part of discharge planning. So, if, for example, oxygen and intravenous (IV) will be stopped before person goes home in two days, do not mark them on the screen. If family is learning to do a 2-person pivot transfer to prepare to use at home, mark that on the screen, even if now the hospital does one-person transfers with a mechanical lift. It will take additional time and talking with facility staff, family, etc., to get the most accurate picture of the person's needs at home, after discharge.

The screener must be able to envision the person at home. This is why screeners must have experience in community care for the target group being screened.

## 1.15 Verifying Diagnoses and Health-Related Services

The Health-Related Services table of the LTC FS is extremely important to determining a person's eligibility. The table collects objective data used by the programmed logic to determine whether the person meets nursing home or DD level of care. This in turn determines eligibility for home and community-based waivers and affects the Family Care eligibility (Comprehensive vs. Intermediate). Accuracy in this information will be a focus in quality assurance and improvement efforts both locally and at the DHFS. The diagnoses will provide important data for evaluating Family Care and other long term care programs, but do not have direct role in the eligibility logics. The target group question (discussed in module 2) may require help from health care professionals as well.

No health care providers' signatures are required on the screen, but screeners must take the time to verify health-related information. Screeners will need to verify diagnoses and health-related services for the LTC FS, and can verify information needed for the target group question at the same time. Explain this to the person, and either get permission to contact their physician's office or help arrange an appointment.

*****In almost all cases, screeners will need to contact a health care provider to get accurate information on health-related services, diagnoses, and, if necessary, the target group question.*****

# Module #2: Long Term Care Functional Screen Target Groups

## Objectives

*By the end of this module you should be able to:*

- Describe the key components that constitute a "long-term care condition" in regard to the LTC FS
- Identify the three primary target groups of people for whom the LTC FS is designed to serve
- Explain the definitions of each target group as it relates to the LTC FS
- Accurately deal with issues of "comorbidity" and multiple diagnosis with regard to the LTC FS

## 2.1 LTC FS Target Groups

**The Long Term Care Functional Screen was designed to assess the needs of people who have "a long-term care condition that is expected to last for more than 90 days related to ~~infirmities of aging~~being a frail elder, physical disability, developmental disability, dementia (onset of any age), or a terminal condition with death expected within one year from the date of the eligibility for long term care services."**

**This breaks into three steps:**

1. Person must have a long term care condition expected to last for more than 90 days, or result in death within one year
2. Person must be in one of the populations or "target groups" intended for Family Care, Partnership, or Wisconsin's home and community-based waiver programs
3. Person in a target group must have ADL/IADL deficits specified for program eligibility

**This means three things:**

1. A person could be temporarily "physically disabled" but not have "a long term care condition expected to last more than 90 days" (EXAMPLE: someone otherwise healthy and independent who breaks a bone.)
2. A person could be in a target group but not eligible for a Wisconsin long term care program -if s/he does not have any ADL/IADL deficits (EXAMPLE: someone with mild cerebral palsy who is fully independent.)
3. A person could have ADL/IADL deficits, but not be eligible for a long term care program-if s/he is not in one of the target groups served by that program (EXAMPLE: someone with only schizophrenia, but no other conditions.)

## 2.2 How to Answer the Target Group Question

*The person has a condition that is expected to last for more than 90 days related to*:

- Frail Elder
- Physical Disability
- Developmental Disability per FEDERAL definition
- Developmental Disability per STATE definition but NOT Federal definition
- Alzheimer's disease or other irreversible dementia (onset any age)
- A terminal condition with death expected within one year from the date of this screening

- Severe and persistent mental illness
- None of the above (No Target Group)

**A person can be in more than one target group. Check all that apply.** (Note: if a person meets the Federal definition of DD, the State definition should NOT be checked.)

The target group question does rely on the professional judgment of the screener applying the **statutory definitions** of these terms.

The statutory definitions are somewhat vague and open to interpretation. The definitions overlap with, but cannot be reduced to, objective data of diagnoses or ADL/IADL needs. Fortunately, county human service staff have been using these definitions for years in current waiver programs. Consult with your peers and managers often. A nurse should be available to assist screeners with questions. For the developmental disability (DD) determinations, a DD logic "decision tree" has been created to help screeners to evaluate whether a person's diagnosis, functioning, and need for active treatment meet the Federal definition of DD. If after collecting all necessary information (such as I.Q. score and diagnoses) and using the "decision tree", consult with staff of the Bureau of Developmental Disability Services if you need further guidance.

**Refer to MD or Psychologist if Necessary**
In some instances, physicians or psychologists will need to be consulted (for example, to help determine whether person meets Federal definition of developmentally disabled). Screeners may occasionally need to help the person get a MD appointment to obtain diagnoses, IQ scores, and to determine whether the person is in one of the target groups. County agencies often have psychologists and psychiatrists who can determine whether an individual meets definitions for developmental disabilities and can help screeners sort through deficits related to mental illness.

## 2.3 Data Entered Elsewhere in the Functional Screen Should Correlate with the Target Group Question

QA Check: If you checked "Alzheimer's or other irreversible dementia" here, there should be a dementia diagnosis checked in the diagnoses table later in the LTC FS. If such data do not correlate, the LTC FS application will produce a warning message to inform you of the error and ask that you adjust the screen. You will not be able to calculate eligibility until all critical data correlate.

**Target Group Definitions**
Each of the statutory definitions is reproduced in bold below, with interpretive guidelines for each.

## 2.4 "~~Infirmities of Aging~~Frail Elder"

**~~Infirmities of aging means organic brain damage caused by advanced age or other physical degeneration in connection therewith to the extent that the person so afflicted is substantially impaired in his or her ability to adequately provide for his or her care or custody (WI Statutes 55. 01(3)).~~"Frail elder" means an individual aged 65 or older who has a physical disability, or an irreversible dementia, that restricts the individual's ability to perform normal daily tasks or that threatens the capacity of the individual to live independently (HFS 10.13(25m)).**

~~Interpretation: This definition is grammatically ambiguous. Read it in the following way:~~

> ~~Organic brain damage caused by advanced age, or other physical degeneration in connection with advanced age, either of which substantially impairs the person's ability to adequately provide for his or her care or custody.~~
>
> ~~"Organic brain damage" is not restricted to the specific diagnosis of organic brain syndrome. Here, "organic" is an adjective to distinguish the brain damage from, say, traumatic head injury.~~

~~"Advanced age" here is interpreted as age 65 or older.~~

***Partnership Sites:*** *Partnership sites should adhere to the 65 or older age guideline for the ~~Infirmities of Aging~~Frail Elder target group. Those consumers who are younger than 65 should be included in the Physical Disability target group if they meet the definition described below.*

For additional assistance in determining if someone meets this target group when they have comorbidities such as mental health and/or AODA, refer to the tool, "Decision Tree for Frail Elders with Co-Morbidities," which is located in the appendices at the end of this manual. It's also available on the DHFS web site at: http://dhfs.wisconsin.gov/LTCare/FunctionalScreen/ComorbiditiesElders.pdf.

## 2.5 "Dementia"

**Dementia means Alzheimer's disease and other related irreversible dementias involving a degenerative disease of the central nervous system characterized especially by premature senile mental deterioration and also includes any other irreversible deterioration of intellectual faculties with concomitant emotional disturbance resulting from organic brain disorder (WI Statues 46.87(1)(a)).**

"Organic brain disorder" here is not limited to the specific diagnosis "organic brain syndrome."

"Irreversible" is something you cannot always tell by diagnosis alone. For instance, alcoholic dementia or drug-induced dementia may or may not be irreversible. You need to consult a health care provider to specifically ask whether the dementia diagnosed is irreversible or not.

It is sometimes impossible to distinguish "organic" brain disorders from "mental illness" or from alcohol or other drug abuse. In fact, the separation makes little sense clinically. You certainly can't tell by looking, and you can't tell by history: A person could have had mental illness but now be manifesting dementia. You need to get some help from a health care professional. If the consumer does not have a health care provider to contact for diagnoses and other information, you'll need to facilitate getting the consumer an appointment for an evaluation.

## 2.6 "Physical Disability"

**Physical disability means a physical condition, including an anatomical loss or musculoskeletal, neurological, respiratory or cardiovascular impairment, which results from injury, disease or congenital disorder and which significantly interferes with or significantly limits at least one major life activity of a person" (WI Statutes 15.197(4)(a) 2).**

**"Major life activity" means any of the following: A. Self-care. B. Performance of manual tasks unrelated to gainful employment. C. Walking, D. Receptive and expressive language, E. Breathing, F. Working, G. Participating in educational programs, H. Mobility, other than walking, I. Capacity for independent living." (WI Statutes 15.197(4)(a)1).**

Note that checking this target group question refers to this statutory definition. It does NOT require a social security determination of disability. (SS disability determination is needed for waiver eligibility, but not for Family Care eligibility.)

For additional assistance in determining if someone meets this target group refer to the tool "Defining Physical Disability for the LTC Functional Screen Target Group," which is located in the appendices at the end of this manual. It's also available on the DHFS web site at: http://dhfs.wisconsin.gov/LTCare/FunctionalScreen/Pddefinition.pdf.

If the person has comorbidities such as mental illness, the person must have a another medical or physical condition to consider separately from the mental illness and the screener must consider whether that condition impairs the person's functioning significantly enough to meet the statutory definition above.

Examples:

- A consumer with chronic mental illness suffered a stroke which results in significant, permanent left sided weakness and cognitive deficits. The consumer needs significant physical assistance throughout the day to complete ADLs, now needs to use a walker and bath equipment, and needs help to complete IADL tasks such as meal prep, money management, and medication management. This person **would meet** the PD target group as well as the severe and persistent mental illness target group.
- A consumer with schizophrenia breaks their leg in an auto accident. The consumer undergoes surgery and their leg is braced to allow it to heal. The consumer needs physical assistance with bathing, dressing and mobility, but with physical therapy, is expected to regain full use of their leg within six weeks. This person **would not** meet the PD target group since the injury is not permanent and will not last for a year or more. However, the person would meet the severe and persistent mental illness target group.

Refer to the tool "Decision Tree for PD with Co-Morbidities" to help determine if they meet this target group. This tool is located in the appendices at the end of this manual. It's also available on the DHFS web site at: http://dhfs.wisconsin.gov/LTCare/FunctionalScreen/ComorbiditiesPD.pdf.

## 2.7 Physical Disability or ~~Infirmities of Aging~~Frail Elder?

In truth, most ~~"infirmities of aging"~~problems associated with being a frail elder are physical disabilities, so in many instances both definitions might apply. (A good example is arthritis, which in an old person is considered age-related, but in a young person is considered a physical disability.) For eligibility purposes, you can check either one or both target groups. To be precise, however:

- Check only "~~Infirmities of aging~~Frail Elder" if the condition developed late in the person's life, i.e., is related to age.
- Check only "Physical disability" if the person had a physical disability at a young age and now just happens to be age 65 or older.
    - Example: A healthy 66-year-old person with paraplegia from an accident at age 43.
- Check both "~~Infirmities of aging~~Frail Elder" and "Physical disability" if both apply to separate conditions.
    - Example: A 66 year old person with paraplegia from an accident at age 43 who also has congestive heart failure and rheumatoid arthritis.

## 2.8 Dementia or ~~Infirmities of Aging~~Frail Elder?

Dementia is listed as a separate target group in order to capture people younger than age 65 with dementia. If the person is 65 or older, both target groups can apply.

- Check only "Dementia" if the person does not have any other conditions that meet the definition of "~~Infirmities of aging~~Frail Elder"
- Check both if the person does have other conditions that meet the definition of "~~Infirmities of aging~~Frail Elder"

## 2.9 Dementia or Mental Illness?

You can't tell by looking, and you can't tell by history: A person could have had mental illness but now be manifesting dementia. You need to get some help from a health care professional. If the consumer does not have a health care provider to contact for diagnoses and other information, you'll need to facilitate getting the consumer an appointment for an evaluation.

# 2.10 FEDERAL Definition of Developmental Disability

**A person is considered to have mental retardation if he or she has - (i) A level of retardation described in the American Association on Mental Retardation's Manual on Classification in Mental Retardation, or (ii) A related condition as defined by 42 CFR 425.1009 which states, "Person with related conditions" means individuals who have a severe, chronic disability that meets all of the following conditions:**

(a) It is attributable to:

1. Cerebral palsy or epilepsy or
2. Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons.

(b) It is manifested before the person reaches age 22

(c) It is likely to continue indefinitely

(d) It results in substantial functional limitations in three or more of the following areas of major life activity: Self-care; Understanding and use of language; learning; mobility; self-direction; or capacity for independent living.

Note that the consumer must meet the Federal definition of DD in order to be eligible for HCBW waivers. DD individuals seeking waiver services must have a disability determination.

County records and school records are often helpful, in addition to or instead of health care records. A written diagnosis of mental retardation or developmental disability suffices. Families or guardians often retain copies of such documentation. For the developmental disability (DD) determinations, if you have all the necessary information (such as IQ score and diagnoses), refer to the DD logic "decision tree" (located in the appendices at the end of this manual. It's also available on) to guide you through the determination process. If you are in need of further assistance, consult with staff of the Bureau of Developmental Disability Services. For additional assistance in determining if someone meets this target group, refer to the Developmental Disabilities resources for certified screeners which are located on the DHFS web site at: http://dhfs.wisconsin.gov/LTCare/FunctionalScreen.

# 2.11 STATE Definition of Developmental Disability

For Family Care: Persons meeting only the State definition but not the Federal definition of developmental disability may still be Family Care eligible. The section below outlines this criteria.

**Developmental disability' means a disability attributable to brain injury, cerebral palsy, epilepsy, autism, Prader-Willi syndrome, mental retardation, or another neurological condition closely related to mental retardation or requiring treatment similar to that required for mental retardation, which has continued or can be expected to continue indefinitely and constitutes a substantial handicap to the afflicted individual. 'Developmental disability' does not include senility which is primarily caused by the process of aging or the infirmities of aging" (WI Statutes 51.01(5)(a)).**

**Wisconsin's definition of DD is broader than the Federal definition**, in that it does not include the restrictive clauses "b" (onset before age 22) and "d" (substantial functional limitations) of the Federal definition. In order to be eligible for the home and community-based waivers for DD persons; the consumer must meet the Federal definition of DD.

If a person meets the Federal definition of DD, they will also meet the State definition of DD. However, you should only check FEDERAL definition of DD on the LTC FS target group section.

For the developmental disability (DD) determinations, if you have all the necessary information (such as IQ score and diagnoses), refer to the DD logic "decision tree". If you need further assistance, consult with staff of the Bureau of Developmental Disability Services. If you do not have necessary information such as IQ score and diagnoses, refer to a MD or psychologist for an evaluation as discussed above.

(Note: Many schools systems have been referring young adults with diagnoses such as learning disorders, attention deficit disorder, hyperactivity, or emotional disturbances, to Resource Centers for Family Care enrollment. In most instances, it is not immediately clear whether or not these young adults meet the Federal definition of DD. To assist in clarifying this issue, use the DD logic "decision tree" guide to evaluate whether the person's diagnosis, functioning, and need for active treatment meet the Federal definition of DD. Again, do not hesitate to call the BDDS for assistance (when you have information on diagnoses and IQ tests.)

## 2.12 Brain Injury

**In most long term care programs, traumatic brain injury is included with the "Physical Disability" target group** (even if the resulting symptoms are only cognitive or behavioral).

A person with brain injury may meet the Federal definition of DD if the injury occurred before age 22. If the brain injury occurred after the age of 22, the person may meet the State definition of DD* but not the Federal definition. Screeners should check both of those target groups (PD plus either federal or state DD) for persons with traumatic brain injury. Brain injury will be evident through the diagnoses table of the LTC FS. Application for the Wisconsin Brain Injury Waiver Program requires a separate process that is more in-depth than the LTC FS. The agency should refer the person to that process if appropriate. Note: The screen cannot currently be used to access the Brain Injury Waiver.

*A special rule only for the State DD definition: If the injury to the brain is vascular in origin it must have occurred prior to age 22.

## 2.13 Terminal Condition

For the purposes of the LTC FS, "Terminal Condition" is defined as a condition where death is expected within one year from the date of the screening. If you check this target group you should also be checking K3 on the diagnosis module and also check the associated diagnosis which has created the terminal condition, e.g., AIDS.

Note: "Terminal" for the LTC FS is 12 months as opposed to 6 months for Hospice patients, and does not require a signed declaration from the primary physician.

## 2.14 Severe and Persistent Mental Illness

For the purposes of the LTC FS, "severe and persistent mental illness" (SPMI) is defined as a mental illness which is severe in degree and persistent in duration, which causes a substantially diminished level of functioning in the primary aspects of daily living and an inability to cope with the ordinary demands of life, which may lead to an inability to maintain stable adjustment and independent functioning without long-term treatment and support and which may be of lifelong duration. "Chronic mental illness" includes schizophrenia as well as a wide spectrum of psychotic and other severely disabling psychiatric diagnostic categories, but does not include organic mental disorders or a primary diagnosis of mental retardation or alcohol or drug dependence.

Example: A person with a diagnosis of situational depression newly diagnosed due to the death of their spouse who is stable, functional, and treated with anti-depressant medication short-term, would not meet this definition. Conversely, a person with a long-standing diagnosis of schizophrenia who refuses treatment, is frequently unstable and hospitalized, would meet this definition.

SPMI is also used to describe a person with a diagnosis of personality disorder, who has persistent difficulty in certain functional areas of their lives which affects their overall quality of life, e.g., inability to follow through with health care, inability to sustain relationships, vocational goals or cannot perform activities of daily living with consistency.

## 2.15 Mental Illness and Substance Abuse ("Comorbidity")

**While "Severe and persistent mental illness" is included in the LTC FS target group choices, LTC programs such as Family Care, Partnership, CIP 1A/1B and COP-waiver require that consumers also have LTC conditions related to another primary LTC target group (~~Aging~~Frail Elder, PD, DD, etc.). Severe and persistent mental illness cannot be the only LTC target group selected if a person is to be found eligible for such LTC programs.**

**"Comorbidity" means having more than one diagnosis; in this document it refers to having a mental illness and/or substance abuse (SA) along with physical disability, ~~infirmity of aging~~being a frail elder or developmental disability.** Estimates are that from **40 to 70% of long term care recipients also have mental illness and/or alcohol or drug abuse (AODA) issues**. In practice, it is sometimes impossible to distinguish mental illness and AODA-related conditions from "~~infirmities of aging~~frail elder" or "dementia."

**To reduce confusion, please follow these steps:**

*First*, ask whether person meets statutory definitions for at least one LTC FS target group: ~~Infirmities of Aging~~Frail Elder, PD, DD, dementia, or terminal condition. To do so, you must focus only on the physical, medical, or cognitive condition you are considering (ignoring their mental illness) and ask whether it satisfies a statutory definition.

If YES: Check "yes" to all target groups that apply, and continue with the screen.

The person may also have mental health or SA issues; as noted above, many LTC consumers do. They are eligible for some long term care programs if they are in at least one target group and if they have functional limitations-i.e., they need help with ADLs/IADLs. Note that this method does NOT ask what the PRIMARY diagnosis is, and it does not ask the reason for the ADL/IADL limitations. So, someone whose "primary" diagnosis is mental illness could in fact be eligible for a long term care program-as long as s/he ALSO has PD, DD, ~~infirmity of aging~~frail elder, dementia, or terminal condition, and ADL/ IADL deficits. Remember that to meet a target group, the person has to have deficits **related** to that particular target group definition.

If NO: If person is known to have ONLY mental health and/or SA issues, none of the LTC FS target groups can be checked because person does NOT have DD, PD, ~~infirmity of aging~~frail elder, or terminal condition in addition to mental illness or SA. Stop there-this person is INELIGIBLE for LTC FS programs. The screening agency should refer the person to other programs, especially mental health, but also Medicaid fee-for-service for help with ADLs/ IADLs.

*Second*, continue with the screen to see if person is functionally eligible, i.e., has ADL/IADL deficits specified in program eligibility criteria. (Again, the screen does not ask the reason for the ADL/IADL deficits.)

Example: 67 year old man with residual schizophrenia also has advanced COPD (chronic obstructive pulmonary disease) and CHF (congestive heart failure) that make him very short of breath and weak. It is clear that the COPD and CHF significantly impair his ability to function. (Or would if he ever tried to do his ADLs/IADLs; providers tend to just do them for him because of his schizophrenia.) Check "~~Infirmities of Aging~~Frail Elder."

## 2.16 Mental Illness Comorbidity and Medications

**As noted in previous section, many people in LTC FS target groups will also have mental illness and AODA diagnoses. It does not matter which diagnosis is "primary." All that matters is that the consumer with mental illness or AODA diagnosis also meets one of the LTC FS target group definitions.**

The statutory definitions allow for consideration of the special instance when a person due to mental illness cannot self-manage a physical disability or infirmity of aging.

If the person is unable to self-manage medications or treatments for a medical condition, then the condition counts as an infirmity of aging or a physical disability if the failure to take the medications is *life-threatening*. Examples include insulin for diabetes, or medications for high blood pressure (to prevent strokes) or medications to prevent blood clots.

The logic involves using a counterfactual: If the person didn't have a medical condition requiring life-sustaining medications, she could probably live on her own despite her mental illness (even if not well, e.g., homeless). But because she has diabetes or high blood pressure requiring medications, and because her failure to take the meds would be *life-threatening*, she cannot live on her own. Therefore, the medical condition does "severely impair her capacity for independent living" or self-care. So the medical/physical condition does meet statutory definition of physical disability or ~~infirmity of aging~~frail elder, so she is in a LTC FS target group.

If the medications are not life-sustaining -i.e., if failure to take the meds is not life-threatening-then the medical condition does not "severely impair her capacity for independent living." Unless it otherwise severely impairs functioning, then it does not meet statutory definition of physical disability or ~~infirmities of aging~~frail elder.

The inability to take only psychotropic medications does not apply here, because there is no separate physical disability or infirmity of aging causing the need for those medications. The mental health system would need to help the person take medications.

This approach may mean that some persons currently being served by mental health clinics – specifically, those who come in daily for meds that include insulin, blood pressure meds, etc-would meet the target group question. Those persons may be functionally ineligible for programs connected to the LTC FS if they do not have a sufficient number of ADL/IADL deficits.

**Family Care Only**: Individuals who are found ineligible for some long term care programs may still be found functionally eligible at the Intermediate or Comprehensive level of Family Care. Family Care eligibility is not the same as eligibility in the current waivers. No Social Security disability determination is needed. Again, applicants must have a separate medical or physical condition (or dementia) to consider separately from the mental illness and they must ask whether that condition impairs the person's functioning significantly enough to meet the statutory definition for a target group.

## 2.17 What If No Target Group Applies?

Explain to the consumer that s/he does not appear to meet any of the statutory definitions for a LTC FS target group, and so is not eligible for programs connected to the LTC FS. **Since the LTC FS is completed after conversations between the screener and consumer, it is expected to be rare that you would even try to do a screen for someone not in a target group.** If a consumer disagrees with the screener about their target group status, the screener should consult with a supervisor and/or refer to a physician or psychologist for an opinion. The screener will also provide counseling and referrals for the consumer's other service options.

The "No Target Group" category automatically makes a person ineligible for the functional screen. If you choose this option you will not be allowed to select any other target group.

**For Family Care Only**: This option is available to use in instances where payment is sought related to screening ineligible people.

## 2.18 Age

The **minimum age** for programs connected to the LTC FS is **18** years of age. However, individuals 17 years 9 months old or older may be screened by the LTC FS to allow for advance planning. If the date of birth entered indicates that the person is younger than this, the application will not allow the screener to proceed.

For HCBW counties the existing process should be used for applicants under the age of 18. Approval is necessary from the Bureau of Aging and LTC Resources for COP-W/CIP II applicants. For CIP I applicants, current process will be used until the children's screen is designed.

## 2.19 HCB Waiver Group

**Note: This question applies to Home and Community-Based Waiver counties and to Resource Center counties without a Care Management Organization. PACE/Partnership and Family Care agencies should not answer this question.**

Select the appropriate waiver type from the drop-down box. This question does not determine waiver eligibility, but allows The Management Group (TMG) or Community Integration Specialists (CIS) from the Bureau of Developmental Disabilities Services to review screen information on-line for quality assurance purposes. However, until further notice, care managers should send paper copies of all information as they have been directed. By selecting "COP-W & CIP II", TMG staff will be able to access the screen. By selecting "CIP 1A" or "CIP 1B", CIS staff will have access to the screen. This question also applies to recertification screens for persons already on a waiver, but who are being screened for the first time using the LTC FS. If the person does not meet waiver level of care or will not be served in a waiver at this time, do not select a waiver type.

# Module #3: LTC FS Basic Information/Screen Information/Demographics/Living Situation

## Objectives

*By the end of this module you should be able to:*

- Identify what basic screen and demographic information is collected by the LTC FS
- Correctly enter demographic information into the LTC FS
- Define what constitutes an “Activated Power of Attorney for Health Care”
- Explain the importance of the “Prefers to Live” question of the LTC FS

**Demographic information collected for the LTC FS does not determine eligibility for LTC services. Demographic information is used for two purposes:**

1. If an applicant chooses to enroll in a LTC program, demographic information will be used as the foundation of the enrollees full comprehensive assessment
2. Demographic information will be used for quality assurance and program oversight by state and county administrators

“Other” boxes are available in some instances to allow you, the screener, to fill in answers that may not be provided in the drop down boxes.

## 3.1 Screening Agency

This is a read-only field that the application will fill in automatically. To transfer a screen to another agency because of enrollment, referral, or applicant's move to another county, the Transfer utility should be used.

## 3.2 Referral Date

Enter the date someone requested that a functional screen be done. For example, use the date a health care provider refers a consumer to your agency or the date a CMO refers a consumer to a resource center. If no one requested the functional screen, enter the date you start it. For example, use the date you start the screen when completing an annual screen or when completing a screen so than an existing participant has a baseline screen in your system.

## 3.3 Date of Birth

Enter the person's date of birth in **MM/DD/YYYY**, as in 01/01/1909. LTC FS programming will not allow dates to be entered that make the applicant more than 150 years old or younger than 17 years, 9 months.

## 3.4 Screen Type

Select one option from the drop down box. There are three screen type options:

- **Screen type 01, Initial Screen**—The first Long Term Care Functional Screen completed for a person interested in understanding his or her long-term care status. Anyone may request a functional screen. Additionally, anyone can be referred for a functional screen.

- **Screen type 02, Annual Screen**—An annual/recertification screen required as long as a consumer is enrolled in a home and community-based waiver program (COP/CIP/W, Family Care, PACE/Partnership). This type of screening is required annually. ***For Family Care Only***: If the consumer was enrolled in a waiver program prior to Family Care, they must continue to be recertified according to the date established with the prior waiver. If the consumer was not enrolled in a waiver program prior to Family Care, the screen must be completed annually no later than the end of the month initial eligibility was established.

- **Screen type 03, Change of Condition**—At any time when a consumer's physical, emotional or living condition changes significantly they may request and/or receive additional screenings. You do not need to expect the change to last over 90 days in order to use this screen type.

**Family Care Only**: **"Was this person offered this functional screen in response to a referral from a nursing home, CBRF, RCAC, or Adult Family Home to a Family Care resource center (PAC)?**" [Check this box] if the resource center offered this screen to this individual in response to a "pre-admission consultation" (PAC) referral from a nursing home, CBRF, RCAC, or Adult Family Home. PAC referrals are made from these facilities when individuals are seeking admission to the facilities or have recently been admitted. [Do not check this box] if the individual came to the resource center, or was contacted by the resource center, through any other means or source.

## 3.5 Street Address/City/State/Zip/Phone Number

**Enter the applicant's "permanent residence" address.** If the person is now in a facility (nursing home, CBRF) that may or may not be their "permanent residence." If a person is now in a nursing home, but maintains their apartment in the community with the intention of returning to home in the next few weeks, their apartment would be their permanent residence-not the nursing home. Use your professional discretion to determine what is the applicant's permanent residence.

"Applicant" is the consumer you are screening as part of application for HCBW, Family Care, Partnership, or other long term care program. Include street number, street name, apartment number, city, and zip. Include telephone number if available.

For transient persons, enter the address they lived at the most in the last 6 months.

## 3.6 County of Residence and County/Tribe of Responsibility

Select the appropriate county/tribe from the drop down box. In most cases these will be the same. In a few instances, persons may live in one county but another county/tribe is responsible for services, costs, and/or protective services. For the purposes of screening, residency is physical presence or the intent to reside.

**Family Care CMO Counties Only**:
For more information, refer to the "Permanent Moves Protocol," which is located on the DHFS web site at: http://dhfs.wisconsin.gov/LTCare/Partners/PDFs/MovesProtocol.pdf.

## 3.7 Location Directions

This space is available for you to enter directions to the applicant/consumer's home. Keep your entries brief and succinct.

## 3.8 Referral Source

Select from the drop down box who (the applicant, a family member, friend, etc.) contacted the screening agency to refer this person for a Screen. If the screen is being completed as an "02-Annual Screen," or "03-Change in Condition Screen," select "Annual Recertification or Change in Condition" from the drop down box.

## 3.9 Primary Source for Screen Information

Select the primary source (person) for screen information from the drop down box. If the primary source is not listed, select other and fill in the other box.

In most cases, the primary source for screen information should be the consumer. Often, screeners will also need to have collateral contacts with family, residential staff, health care providers.

In some instances information will be obtained almost equally from multiple sources. "Primary" means the majority, over 50 %. Please select the source that seems most accurate.

If the consumer uses an interpreter, the consumer -- not the interpreter-- is still the primary source of information.

This question is meant as a quality assurance reminder that screeners must not take shortcuts and complete a screen by only talking with caregivers, staff, etc. If the applicant could participate in the screen, the applicant should participate in the screen interview. If the person is not the primary source of information, it is expected that in most cases other parts of the screen will indicate significant cognitive limitations. It will also be used in research to explore differences in LTC FS depending on who provides information.

## 3.10 Where Screen Interview Was Conducted

Select the place where the screen was conducted from the drop down box.

"Person's current residence" includes private homes, residential facilities, or nursing homes.

"Nursing home" includes ICF-MRs and FDDs. Select "nursing home" if the nursing home is not the consumer's primary residence (i.e. they have a permanent residence elsewhere). If the nursing home is the consumer's primary residence, select "person's current residence" instead. We know that this question is not always easy to answer and rely on screeners' experience and expertise to select the most accurate answer.

"Temporary residence (non-institutional)" is intended for instances when consumer is staying with family or friends temporarily, for instance to recuperate from an illness or surgery. It also includes temporary stays in residential facilities, such as respite in a CBRF. Do not select this if the person is in an institution such as hospital or nursing home.

If you select "Other" please write a description such as Resource Center or county office.

## 3.11 Medical Insurance

**Check ALL that apply.**

If Medicare is checked, enter the person's Medicare number, and check box to indicate Part A or B or Medicare Managed Care as applicable. (Note: Medicare Managed Care is a new form of voluntary HMO Medicare called "Medicare Plus Choice." You may see it written as "M + C". If the person has Medicare

Gold, check the “Medicare Managed Care” box.) The effective dates for Medicare Part A or B are optional to complete.

Private insurance includes employer-sponsored insurances (e.g., an HMO) available as a job benefit. BaderCare and MAPP are forms of Medicaid. If the person is on BadgerCare or MAPP, enter this information under Medicaid with the number, and put a comment about this information in the Notes section.

## 3.12 Race/Ethnicity

**RACE**

This is NOT a required field. Please select all boxes that apply. For persons with mixed heritage you can check all boxes that apply or check “Other” and write in the multiple races. The choices here match federal insurance reporting requirements. If needed, use the following definitions to identify the appropriate option:

- **Black or African American**:
  “Black” refers to people having origins in any of the Black racial groups of Africa. It includes people who indicate their race as “Black,” ~~African Am., or Negro,” or as~~ African American, Afro-American, Nigerian, or Haitian.

- **Asian or Pacific Islander**:
  “Asian” refers to people having origins in any of the original peoples of the Far East, Southeast Asian, or the Indian subcontinent. It includes people who indicate their race or races as “Asian Indian,” “Chinese,” “Filipino,” “Korean,” “Japanese,” “Vietnamese,” or “Other Asian,” or as Burmese, Hmong, Pakistani, or Thai.

  “Pacific Islander” refers to people having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. It includes people who indicate their race or races as “Native Hawaiian,” “Guamanian or Chamorro,” “Samoan,” or “Other Pacific Islander,” or as Tahitian, Mariana Islander, or Chuukese.

- **White**:
  “White” refers to people having origins in any of the original peoples of Europe, the Middle East, or North Africa. It includes people who indicate their race as “White” or as Irish, German, Italian, Lebanese, Near Easterner, Arab, or Polish.

- **American Indian or Alaskan Native**:
  “American Indian and Alaska Native” refers to people having origins in any of the original people of North and South America (including Central America), and who maintain tribal affiliation or community attachment. It includes people who indicate their race or races as Rosebud Sioux, Chippewa, or Navajo.

- **Other**:
  Check this box if the person does not meet any of the other racial definitions listed above and enter a comment to explain.

**ETHNICITY**

This is NOT a required field. If needed, use the following definition to identify the appropriate option:

- **Spanish / Hispanic / Latino**:
  A person of Mexican, Puerto Rican, Cuban, Central, South American, or other Spanish culture or origin, regardless of race. (Hispanics and Latinos may be of any race.)

## 3.13 Interpreter Language Required

Leave this box unselected if no interpreter is needed.

Select the appropriate language if an interpreter is needed. If “Other,” please type in the language needed. Human service and health care providers should always obtain interpreters when they are needed. This information will help show the extent of such needs, and will also help long term care programs better serve non-English speaking consumers.

## 3.14 Contact Information

The valid contact types to list here are:

- Adult Child
- Ex-Spouse
- Guardian of Person
- Parent/Step-Parent
- Power of Attorney
- Sibling
- Spouse
- Other Informal Caregiver/Support (an ‘Other’ text box must be filled in if 'Other' is selected.)

If the person does have a valid contact to list, check the box and provide the contact’s name, phone number and full address. This information is needed to complete the screen, and to notify the contact of the consumer’s eligibility determination if appropriate.

If there is shared guardianship, you can write in the second guardian’s name and address in the Contact Information 2 area.

Representative payees and un-activated power of attorneys were not considered necessary for this screen and should not be listed in the Contacts section. Some people may have a durable power of attorney document drafted by their attorney that they think has been active from the time it was initially drawn up. However, such documents do not count as an “Activated POA for health care.” Such a POA is “in force” when it is first filled-out, but the consumer makes all her own decisions until she loses capacity to do so. The HCPOA cannot make decisions for her until after she is incapacitated. That is what is meant on the screen by “activated.” A health care POA is “activated” only after the consumer has lost decisional capacity. Activation is usually documented as a doctor's note or addendum to the HCPOA.

## 3.15 Current Residence

Select the appropriate answer from the drop down box menu. If you need to select other, type in an explanation in the “other” box.

Most of the drop down box menu options are self-explanatory. For further clarification:

- Residential Care Apartment Complex (RCAC) is what is commonly (or formally) known as “assisted living”.
- CBRFs include “group home.”
- Other IMD = Other Institute for Mental Disease.
- If an applicant lives with family who is being paid as an adults family home, select “lives with spouse/partner/family.”
- If an applicant lives with family who is being paid to provide services such as personal care, select “lives with spouse/partner/family.”
- If applicant lives with non-related roommates and has a live-in paid caregiver, select “lives with live-in paid caregiver.”

- If applicant is currently in a hospital or nursing home for rehabilitation, but they maintain a home elsewhere (example: an apartment), then the home elsewhere (example: an apartment) is their current residence.

## 3.16 Prefers to Live

Select the appropriate answer from the drop down box menu.

The “Prefers to Live” question asks precisely and only for the consumer's own stated preference. It will be used to see if long term care consumers are living where they want to live and to track changes over time. This question is asking the PERSON'S INFORMED PREFERENCE. **Record where s/he would like to live-not where anyone else wants them to live, and not where you or others think is realistic.** Screeners must take the time to explain the person's options. The consumer cannot express a preference if the screener has not informed them of their options first.

It is well known that people often acquiesce to whatever they feel limited to or whatever they've been told. For example, people with developmental disabilities who live in institutions often think “group home” is the only option available to them. You must take the time to ask questions to help the person articulate her/his preferences. Some people like to live with others; others highly value having their own space. While the person's preference may be difficult to ascertain, screeners are to use their best interviewing skills to select the most accurate answer.

As another example, an old woman may say she “belongs in” a nursing home because she'd be too much of a bother anywhere else. The screener should take the time to ask what she would like, not what she thinks is reasonable.

Screeners should select the answer that most accurately reflects what the person is saying. An elder may articulate a preference for “an apartment with onsite services (RCAC, independent apartment CBRF).” But if a person with developmental disability is telling you that she just wants “a place of my own,” then you select the most appropriate selection of “own home or apartment”. Do NOT select “someone else's home or apartment” or an “apartment with services” even if that is probably what the person would get. The purpose of this question is to record what the person says, not what the system will provide or what you think s/he really needs.

Note: “Own home” can also include life estate situations where the elder has sold the property to another and retains the right to live there.

Select “Unable to determine person's preferred living arrangement” if the person cannot comprehend their options and/or cannot communicate their preference.

If the applicant's preferred living situation is not listed, select “Other” and please type in what the “Other” is, for possible screen revisions in future.

## 3.17 Guardian/Family's Preference of Living Arrangement for this Person

This question was added because screeners found completing the “Prefers to Live” too difficult to answer when the guardian or family disagreed with the consumer being screened. Select the most appropriate option from the drop down box menu.

# Module #4: Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)

## Objectives

*By the end of this module you should be able to:*

- Define the six activities that make up the Activities of Daily Living section and the seven activities that make up the Instrumental Activities of Daily Living section of the LTC FS
- Apply the rating system used with each ADL/IADL accurately and reliably-meaning that other screeners would select the same answer you did
- Properly code “who will help in next 8 weeks” for each ADL/IADL
- Identify the adaptive equipment items that are included in the ADL section of the LTC FS
- Appropriately rate applicant's ADLs/IADLs when discharge from a nursing home or hospital is imminent
- Utilize strategies to counter consumers' tendency to underrate/over-rate their need for assistance with ADL/IADLs

## 4.1 Overview of ADLs/IADLs

The Long Term Care Functional Screen (LTC FS) collects data on consumer's ability to accomplish Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). Many times consumers have adapted to a deficit, may appear fairly functional, but still have the underlying deficit. Be careful not to overlook deficits because of adaptations made. Identify the need and mark the level of help needed. If a person is claiming they are independent in most activities, be sure to check with collateral contacts if you suspect otherwise.

If you have identified a level of help needed in ADLs or IADLs, be sure to mark a diagnosis that correlates to the deficit. This is also true for the other modules where deficits are noted.

**The six ADLs measured in the LTC FS are:**

1. bathing
2. dressing
3. eating
4. mobility
5. transferring
6. toileting

Note: Personal hygiene such as grooming and mouth care are not captured on the LTC FS. This information as well as hygienic conditions of the home should be captured on a comprehensive assessment.

**The six IADLs measured in the LTC FS are:**

1. meal preparation
2. medication management and administration
3. money management
4. use of telephone

5. transportation
6. employment

Note: Employment is not traditionally considered an IADL, but is on the LTC FS. On the LTC FS, chores and laundry are included in the IADL section but do not "count" as IADL deficits in the current eligibility logic. (Also included in this section is a question regarding Overnight Supervision, however this is not an IADL.)

**Each ADL and IADL has its definition provided in the LTC FS. Follow those definitions closely.**

**ADL RATING SYSTEM:**

- **0**: Person is **independent** in completing the activity safely
- **1**: Help is needed to complete the task safely but **helper DOES NOT have to be physically present throughout the task**
- **2**: Help is needed to complete the task safely and **helper DOES need to be present throughout the task**

Note: Help can be supervision, cueing, and/or hands-on assistance (partial or complete).

If a person can complete a task independently, but it takes them a very long time, you need to consider if the person needs any help with that task to complete it safely. If they are in fact completing tasks safely, it does not matter if it takes two or three times longer than for most people. However, if there were significant hardship or negative outcomes for that consumer doing the task so slowly, than it would be justified to mark the person as in need of help completing the task.

***Definitions and Discussion of ADLs**:*

# 4.2 Bathing

- The ability to shower, bathe or take sponge baths for the purpose of maintaining adequate hygiene. This also includes the ability to get in and out of the tub, turn faucets on and off, regulate water temperature, wash and dry fully. (Bathing adaptive equipment counted in the LTC FS are: shower chair, tub bench, grab bars, mechanical lift.)

***Bathing Examples***

Examples of Level of Help Needed = 1 (Helper does not need to be present throughout task"):

- Elderly person only needs help getting in and out of the bathtub, but is safe sitting in tub alone and can bathe self. Helper is present at beginning and end, but does not have to be present throughout the task.
- DD person needs someone to tell him to shower, gather towel, etc., and to turn on the water so he won't scald himself. He is then safe alone in the shower, so helper can leave.

Examples of Level of Help Needed = 2 (Helper does need to be present throughout task"):

- Elderly person takes a shower and is not safe standing in shower alone due to risk of falling, and/or cannot wash self.
- DD person needs someone present throughout the shower to talk him through every single step or to provide hands-on assistance.

Rank the person on how they would prefer to bathe. If they are giving themselves a "sponge" bath because they are unable to get in and out of tub or shower, rank the level of help they need in order to take a tub or shower. If they actually prefer to sponge bathe (and can do so independently), rank them as "0," independent with bathing.

It is not uncommon for consumers to under-rate their need for help with bathing. Remember to use these three steps when rating level of help needed:

1. Seek more details.
2. Seek collateral informants, other people you could ask for additional information.
3. Use your professional judgment to select what seems to be the most accurate answers. Follow the definitions and instructions for the screen.

Example: Bert tells you he doesn't need any help with bathing. He lives alone. He is unkempt and smelly. He walks very unsteadily with a cane, is bent over, and is unable to lift either leg off the floor when you ask him to. It's quite clear to you that he is not able to safely get into and out of his bathtub and that he in fact has not bathed for many weeks.

Step 1: Seek more details.

- You ask him if you can see his bathroom, where you notice that he has a claw-foot bathtub with sides about 2 feet high off the floor (with no grab bars, bench, or non-slip mats). You observe his ambulation and ask him to lift his foot high for you. You ask him for details on how he gets in and out of the bathtub.

Step 2: Seek collateral informants.

- Bert's daughter referred him to the Resource Center and is present during the screen interview. You speak to her privately on the way out to get her perspective on her dad's functioning. She says he's lying now because he's afraid, but he's admitted to her that he is unable to get into the bathtub.

Step 3: Use your professional judgment to select the best answer.

- You can see from Bert's general body movement that he would need help with all aspects of bathing, not just getting in and out of the tub. For bathing you select box 2, “Helper needs to be present throughout the task.”

The fact that someone is receiving a bath at an adult day care center does not automatically mean they should be ranked a “2” for level of help needed. Screener should ask for details and observe consumer's general mobility, steadiness, report of safety, reports of dizziness, ability to reach feet and over head, etc. It may be that a level of help “1” is more accurate than “2.”

If person does not currently have adaptive aids or safety equipment such as grab bars or tub bench, indicate the level of help they need from another person now, without such equipment.

If the facility routinely installs grab bars or other equipment, rank the person on whether or not s/he actually uses the equipment. Remember, you are trying to describe the person's functioning, not the services they receive.

In a situation where a person is getting in and out of the bathtub by himself, but it is really not safe for him to do so, you should describe the help the person needs from another person, regardless of what help he is currently getting. In such an instance, you would mark level of help “box 1” and you would mark support indicator “N”.

However, “needs” and “safety” here should not be over-interpreted. The LTC FS is intended to be an objective screen of people's need for assistance. Thus, you should ask yourself, “would another screener of another discipline rank the person the same way?”

## 4.3 Dressing

- The ability to dress and undress as necessary and choose appropriate clothing. Includes the ability to put on prostheses, braces, and/or antiembolism hose (e.g., "TED stockings") with or without assistive devices. Includes fine motor coordination for buttons and zippers. Includes choice of clothing appropriate for the weather. (However, difficulties with a zipper or buttons at the *back* of a dress or blouse do not constitute a functional deficit.)

Dressing includes dressing top half of body, dressing bottom half (e.g., putting on undies and pants), getting shoes and socks on and off, and applying prostheses, braces, or "TED" stockings with or without the use of assistive devices. It also includes fine motor coordination for buttons and zippers. Dressing IADL includes choice of clothing appropriate for the weather. (However, difficulties with a zipper or buttons at the back of a dress or blouse do not constitute a functional deficit.)

If the person only needs help with part of the dressing task, select Level 1, because helper does not have to be present throughout the entire task of dressing. For example, a person with DD who needs their clothes laid out, but can put them on. The helper does not need to be present throughout the entire task.

To ensure inter-rater reliability throughout the ADL/IADL sections of the LTC FS, you should always ask yourself, "Would another screener (perhaps of another discipline) rank the person the same way?"

~~If a person can complete a task independently, but it takes them a very long time, you need to consider if the person needs any help with that task to complete it safely. If they are in fact completing tasks safely, it does not matter if it takes two or three times longer than for most people. However, if there is significant hardship or negative outcomes for that consumer doing the task so slowly, than it would be justified to mark the person as in need of help completing the task.~~

## 4.4 Eating

- The ability to eat and drink using routine or adaptive utensils. This also includes the ability to cut, chew, and swallow food. (Note: If person is fed via tube feedings or intravenous, check box 0 if they can do themselves, or box 1 or 2 if they require another person to assist.)
- Do not reflect a level of help needed if the person is on a diet and needs portion control. Do not use for "messy" eaters, if they take other people's food, or if the refrigerator must be locked to deter snacking or stealing food.
- Reflect a level of help needed if the person needs to be monitored during eating to prevent choking, aspiration, or other serious complications. Additionally, reflect a level of help need if the person has Prader-Willi Syndrome and all food access must be controlled.

## 4.5 Mobility in Home

- The ability to move between locations in the individual's living environment-defined as kitchen, living room, bathroom, and sleeping area. For purposes of the functional screen, this excludes basements, attics and yards. (Mobility adaptive equipment counted in the LTC FS are: walker, cane/quad cane*, crutches, wheelchair, or scooter **used in the home**; has prosthesis.)

You can use the "Get Up and Go Test" to help determine a person's ability to be mobile. If a person can get up from a chair, walk ten feet, turn around, return to the chair and sit down within 11 to 20 seconds without the use of an adaptive aid, then you could mark them as Independent for mobility. If this activity takes more than 20 seconds, mobility is impaired and you should list some level of help needed.

If the consumer needs to use the furniture or walls to move, they are not independent in mobility. Indicate a level of help needed.

*A cane intended solely as a probe to identify obstacles or as an indicator of visual impairment does not count as an aid for mobility in the home. If the cane also serves the purpose of supporting weight to assist in walking, it may be counted.

## 4.6 Toileting

- The ability to use the toilet, commode, bedpan, or urinal. This includes transferring on/off the toilet, cleansing of self, changing of pads, managing an ostomy or catheter, and adjusting clothes. (Toileting adaptive equipment/aid counted in the LTC FS are: grab bars, commode, hi-rise toilet, ostomy, urinary catheter, or regular bowel program; check the appropriate box relating to incontinence for the person.) Incontinence of bowel or bladder counts here.

## 4.7 Transferring

- The physical ability to move between surfaces: from bed/chair to wheelchair, walker or standing position. The ability to get in and out of bed or usual sleeping place. The ability to use assistive devices for transfers. Excludes toileting transfers. (Transferring adaptive equipment counted in the LTC FS are: mechanical lift, transfer board, grab bars, or trapeze.)

***Definitions and Discussion of IADLs**:*

## 4.8 Meal Preparation

- The ability to obtain and prepare routine meals. This includes the ability to independently open containers and use kitchen appliances, with assistive devices if uses them. Meal prep does include the cognitive and physical ability to obtain groceries, but does not include transportation to and from grocery store (which is captured in "Transportation" IADL).
- If the person is fed via tube feedings or intravenous, treat preparation of the tube feeding as "meal prep", and indicate level of help needed.

MEAL PREPARATION RATING SYSTEM

- 0: Independent
- 1: Needs help from another person weekly or less often
- 2: Needs help 2 to 7 times a week
- 3: Needs help with every meal

If the person can complete this task independently, but it takes them a very long time, you need to consider if the person needs any help to complete it safely. If they are in fact completing it safely, it does not matter if it takes two or three times longer than for most people. However, if there were significant hardship or negative outcomes for that consumer doing meal prep so slowly, then it would be justified to mark the person as in need of help completing the task.

***Meal Preparation***

Meal Prep or Transportation? Ms. Smith cannot get groceries because she cannot drive. However, once she is at the store she could select her own groceries. Remember that transportation has its own question, so you would exclude issues related to driving when considering meal preparation.

Meal prep or not? Do not record a level of help required if the person mostly/always eats microwave food. This does not reflect a deficit. Do not record a level of help required if the person's groceries are bagged lightly. This does not reflect a meal prep deficit.

# 4.9 Medication Management and Administration

Medication Management and Administration IADL includes three things:

1. **Taking/Administering medications** -- *this includes assistance with pre-selected medications such as verbal reminders to take meds or hands on assistance, as well as the ability to judge whether a medicine should be taken or withheld due to symptoms or side effects.* Reflect level of assistance needs with regularly scheduled medicine not "as-needed" medicine. The type of medicine can be brand name, generic or over-the-counter (OTC).
2. **Setting-up medications** -- *this includes pharmacy bubble-packs and any pre-filled "set up" system (boxes, machines, syringes) that a nurse or other trained person (including family members) prepare for the person.*
3. **Monitoring medications** (for effects, side effects, adjustments) - **and/or blood levels** including "finger sticks" for blood sugar -- *Monitoring (including blood levels) must be skilled monitoring for the effects and side-effects of medicines dispensed. Monitoring and blood levels only count if the consumer cannot adjust the medication dosage themselves based on the laboratory report or doctors orders; they need someone else to adjust the medication.*

MEDICATION MANAGEMENT and ADMINISTRATION RATING SYSTEM

- NA: Has no medications
- 0: Independent
- 1: Needs help 1 to 2 days a week or less often.
    - (The minimum frequency here is one month. Ignore frequencies of less than one month.)
- 2a: Needs help at least once a day 3-7 days per week --CAN DIRECT the task and can make decisions regarding each medication.
- 2b: Needs help at least once a day 3-7 days per week --CANNOT direct the task; is cognitively unable to follow through without another person to administer each medication.

***Medication Management and Administration:*** *QA Check:* The LTC FS application will check to ensure that the level of help indicated in the Medication Management IADL correlates with the Medication Administration and Medication Management rows of the HRS Table (discussed in Module 6). The Medication Management IADL includes all of the tasks associated with the Med Management and Med Administration rows of the HRS Table. Thus, if a person is marked independent in Med Management IADL, it will be expected that they are marked independent in *both* Med Administration and Med Management in the HRS Table. If either (or both) of the Med Administration or Med Management rows of the HRS Table are selected, an equivalent frequency of help must be selected on the Med Management IADL.

# 4.10 Money Management

- The ability to handle money, pay bills, plan, budget, write checks or money orders, exchange currency, handle coins and paper work, i.e., to do financial management for basic necessities (food, clothing, shelter). Do not check 1 or 2 if limitation is only cultural (e.g., recent immigrant who has not learned U.S. currency and/or English language).

MONEY MANAGEMENT RATING SYSTEM

- 0: Independent
- 1: Needs help from another person weekly or less
- 2: Needs help from another person daily or more often

***Money Management***

Money Management or Language Barrier? Mrs. DeGaul recently moved from France to Milwaukee to live with her son. Due to her limited English skills, she is unable to manage her money, even though in Paris

she had no problem when dealing in francs. In this case, you would mark Mrs. DeGaul “0” -Independent and write a note to explain. If a person's inability to manage money is due solely to a language barrier and not due to a cognitive or physical disability the person should be considered independent.

Money Management or Transportation? Mr. Rogers is able to manage his own money, pay his bills, and budget his finances, but he is unable to independently get to and from his home to the bank or to the mailbox. In this case, Mr. Rogers would be marked as “0” independent with money management. The transportation issue would be captured in the transportation IADL question.

## 4.11 Laundry and/or Chores

- The ability to do housekeeping, home maintenance, shoveling, etc. “Chores” does NOT include heavy-duty cleaning done infrequently such as carpet, drapery, and window cleaning.

LAUNDRY AND/OR CHORES RATING SYSTEM

- 0: Independent
- 1: Needs help from another person weekly or less often
- 2: Needs help more than once a week

***Laundry and/or Chores***

This IADL item was added per screeners' requests, but plays no role in the eligibility logic. It was not included in the list of ADLs and IADLs developed by the LTC Redesign eligibility workgroup in 1998. Screen research will determine whether this is useful information to capture on the screen.

## 4.12 Telephone

The ability to dial, answer, and use phone, with assistive devices if uses them.

- 1a: Independent. Has cognitive and physical abilities to make calls and answer calls
- 1b: Lacks cognitive or physical abilities to use phone independently

  -and-

- 2a: Currently has working telephone or access to one
- 2b: Has no phone and no access to phone

***Telephone***

This IADL regards the person's cognitive and physical ability to use the phone, with assistive devices, if used.

“Access to phone”- was added per screeners' requests, but plays no role in the eligibility logic. Screeners wanted it there to capture the true nature of a consumer's situation and to warn the CMO that they would have to deal with a person with no phone access. Even if the person is unable to use the phone due to a cognitive or physical limitation, it is good to know whether or not the family or workers have access to a phone, as this could impact service delivery.

## 4.13 Transportation

- The ability to drive regular or adapted vehicle

TRANSPORTATION RATING SYSTEM

- 1a: Person drives regular vehicle
- 1b: Person drives adapted vehicle
- 1c: Person drives regular vehicle, but there are serious safety concerns
- 1d Person drives adapted vehicle, but there are serious safety concerns
- 2: Person cannot drive due to physical, psychiatric, or cognitive impairment
- 3: Person does not drive due to other reasons

## 4.14 Employment

- The ability to function at a job site. This question concerns the need for employment-related assistance. Since the need for help with ADLs and IADLs is captured in other sections, this question essentially covers job coach duties.

EMPLOYMENT RATING SYSTEM

*A. Current Employment Status & Interest:*
- A1: Retired
- A2: Not employed
- A3: Employed full time
- A4: Employed part-time
- I: Interested in new/different job
- N: Not interested in new job

*B. If Employed, Where:*
- B1: Attends pre-vocational day activity/work activity program
- B2: Attends sheltered workshop
- B3: Has a paid job in the community
- B4: Works at home

*C. Need for Assistance to Work:*
- C0: Independent (with assistive devices if uses them)
- C1: Needs help weekly or less (e.g., if problems arise)
- C2: Needs help every day but does not need the continuous presence of another
- C3: Needs the continuous presence of another person

## 4.15 Overnight Care

“Does Person Require Overnight Care or Supervision?” Overnight Care is not an ADL or an IADL but is included in this section.

Please remember: all people currently residing in ICF-MRs and nursing homes DO NOT necessarily require overnight care. You should ask yourself, “Would this person require overnight care were they not residing in an institution?” You should also ask the institution's staff whether or not the person being screened has ever demonstrated independence on the night shift. Does the person use the call bell at night? Or rather do they get themselves to and from the bathroom at night independently? Simply because the institution staff has a policy to monitor everyone at night, does not necessarily mean that the person requires over night care.

## 4.16 Level of Help and LTC Costs

**In general, the ratings for “level of help needed” correlate with costs for LTC services.** ADLs rating 1 indicates that helper does not have to be present throughout the task. This rating is generally less expensive than rating 2, in which helper does have to be present throughout the task-at least in

congregate settings. Rating 1 captures the common scenario in CBRFs where one helper can handle several residents, each of whom may only need reminders, cues, setup, or brief help with only parts of each ADL. Rating 1 might take only two minutes to get someone started with a shower or bath, while Rating 2 might take 15 or 20 minutes to actually be there throughout the task. Note that Rating 2 includes all cases in which the helper has to be present throughout the task: It does not ask whether the helper is doing the task completely, helping partially, or just providing verbal cueing and supervision for every part of the task. Since the labor costs are generally the same, these descriptive differences are ignored to make a more simplified LTC FS. Also, it is understood that Rating 1 (e.g., helping someone in and out of a bathtub) usually costs the same as Rating 2 if the helper is making a visit to the consumer's home.

In the IADLs, the ratings correlate with frequencies of interventions needed (monthly, weekly, daily, etc.), which in turn generally correlate with LTC costs.

Not all LTC costs are captured on the LTC FS, in order to keep the screen as brief as possible. In managed care, some things can be allowed to average out among the LTC populations. Further statistical analyses are being done to make the LTC FS a succinct but accurate predictor of consumers' LTC needs and costs.

## 4.17 ADL Rating System

- **0**: Person is **independent** in completing the activity safely
- **1**: Help is needed to complete the task safely but **helper DOES NOT have to be physically present throughout the task**
- **2**: Help is needed to complete the task safely and **helper DOES need to be present throughout the task**

Note: Help can be supervision, cueing, and/or hands-on assistance (partial or complete).

## 4.18 IADL Rating Systems (Vary by IADL)

**While one rating system has been developed for all of the ADLs, the IADLs require separate ratings because their respective descriptions are so different.**

**In all cases, the rating has been simplified to meet the following criteria:**

- Simplicity for maximum uniformity (inter-rater reliability): This is imperative for accurate and equitable determination of eligibility and entitlement.
- Inclusive: A screener is able to select one “most accurate” answer, without lying, for every individual of any of the LTC FS target populations.
- Make sense for eligibility: Some things should not “count” toward eligibility for a LTC program.
- Relate to long term care costs.

## 4.19 Choosing Level of Help Ratings for ADLs/IADLs

Each ADL has its own definition purposefully constructed for the purposes of the LTC FS. Screeners are to follow the definitions precisely in order to select the most accurate rating for level of help needed.

**Always select the answer that most closely describes the person's need for help from another person--whether they are actually getting that help or not. Always select ONLY ONE rating of help needed with each ADL and IADL.**

For each ADL and IADL, **indicate the amount of help the person currently needs from another person-no matter who is providing the help, and no matter where**. The only exception to this is when a person is about to move very soon, estimate what they'll need in their new setting.

## 4.20 Discharge Imminent

If the person is now in a hospital or nursing home, and will go home in the next few days, **record the help they'd need at home**. Talk to the discharge planner, family, person, PT, OT, etc., to get the most accurate possible picture.

## 4.21 Adaptive Equipment

Some of the ADLs (Bathing, Mobility, Toileting, and Transferring) have some adaptive equipment listed. **Check any equipment that the person currently has.** Sometimes a person will improvise to meet a need for equipment. For example, instead of a tub bench they may use a picnic cooler or other sturdy object during bathing. In this instance you would check the bathing equipment box. Capture the use of informal pieces of equipment which clearly substitute for the equipment on the list and reflect need due to functional deficit. **Do NOT check off any that the person seems to need but does not have yet.** Not all adaptive aids are included on the LTC FS. Their omission is intentional. This is a compromise between the current Wisconsin COP eligibility (in which use of any adaptive aids “counts” toward eligibility) and the alternative approach that if a person independently performs a given ADL with adaptive aid, that ADL does not “count” toward eligibility. The compromise in the LTC FS is that only significant durable medical equipment counts toward eligibility. So, for example, wheelchairs and walkers count but some other types of equipment do not count toward eligibility.

A person's untried potential for using assistive devices should not be considered. Note that the person may need help due to physical limitations, cognitive impairments, or both. **Screeners should focus on the person’s level of assistance need, not just that the piece of equipment is in the home**.

## 4.22 Coding for Who Will Help in Next 8 Weeks

**For each ADL and most of the IADLs there are codings to indicate who will help in the next 8 weeks. Check all that apply.**

- U: Current UNPAID caregiver will continue.
- PP: Current PRIVATELY PAID caregiver will continue.
- PF: Current PUBLICLY FUNDED paid caregiver will continue.
- N: Need to find new or additional caregiver(s).

This is for information only. It does not affect the consumer's eligibility for LTC programs.

The level of informal or private pay help will NOT affect a person's level of payment in the new system. (It will all average out, between persons with a lot of informal help and persons with none.) The information will be used for two purposes:

1. To inform the LTC program that the consumer may need services immediately or soon. The 8 week period is rather arbitrary; it is to warn the LTC program when they have less than 2 months to find additional helpers for the consumer.
2. For DHFS research. This information is needed to understand low costs for persons with high needs, so that adequate average payments can be established.

If the level of help needed for a particular ADL/IADL is “0” (or “NA”), the boxes for “Who will help in next 8 weeks” should be left blank. If the person does need help with a task, the “Who will help in next 8 weeks” category is mandatory. In other words, if level of help is greater than 0, you must check at least one of the “Who will help” boxes.

The screener must speak with the consumer and her/his caregivers to know whether the current supports can last for 8 weeks and beyond.

Do not check “N - Need to find new or additional caregiver(s)” if all that is needed is occasional respite.

This will be captured in the LTC FS “Risk Module,” which has additional questions about respite and caregivers.

“PF--Publicly Funded” includes Medicare, Medicaid, waiver funds, and any other federal, state, or county funds.

“PP--Privately paid” means non-public funds-including the person's own money, or that of family, friend, etc., or private insurance, or a trust fund. (If it is the person's out-of-pocket expenses, it will count as medical/remedial expenses in financial eligibility determinations.) Private pay here includes co-pays if they are paid for a particular service. Medicare and Medicaid home health and personal care services do not have co-pays, so those are just “PF-Public funded.”

## 4.23 Nursing Home/Hospital Resident

Often Nursing Home and Hospital staff provide help to people with their ADL/IADL tasks, even if they are able to do the task for themselves. For example, nursing home and hospital staff may manage a resident's medications for them, even if that person is able cognitively and physically to manage their medications independently. Screeners need to interview the person, their family members, and care providers carefully to understand what are their true ADL/IADL needs. **Remember, the LTC FS is meant to record applicant's need for ADL/IADL assistance, NOT what services they are receiving**.

If the person is to be discharged within the next few days, remember to indicate what the consumer's ADL/IADL needs will be when they get home (as discussed above in 4.20).

If a person resides in a nursing home and there is no discharge expected in the next 8 weeks, indicate how the nursing home is being paid: PP or PF. If a person is in a nursing home and they are expected to be discharged very soon, then try to be as accurate as possible with the “Who will help” box. Many elders would go home with a mixture of Medicare and unpaid family help (PP and PF).

## 4.24 Competent Persons

**Note that the definitions are of “the ability to” perform the ADL/IADLs.** If a competent person with full decisional capacity makes the informed choice to mishandle her finances or eat junk food, they may nonetheless be marked “0- Independent” with IADLs. A competent person choosing to gamble or to spend all his money on cigarettes and junk food are commonly-cited examples of such people. You should not indicate that they need help from another person with meal prep or money management unless they are unable to manage them.

## 4.25 Communal Living Situations

Activities of Daily Living (ADLs) are basic activities essential to daily life for all individuals. They include bathing, dressing, eating, toileting and moving around in the environment. Instrumental activities of daily living (IADLs) are tasks an individual **may** need to perform in order to undertake the basic activities of daily living. They include meal preparation, medication management, money management, laundry and housekeeping, using a telephone and transportation. The ADL/IADL section of the functional screen is intended to determine whether a health condition results in an individual being unable to perform an activity or having difficulty performing an activity by himself or herself and without special equipment.

A determination that an individual is limited in her or his capacity to perform an ADL or IADL should always equate with **loss of function**. If a person has never performed an activity or a task, then there is no direct evidence that the person is capable of doing so. However, screeners should not assume that lack of experience is the same as inability to perform a task. Nor should screeners assume that just because a person is receiving assistance with an ADL or IADL he or she is unable to perform the activity independently.

Screeners may encounter individuals living in congregate settings like convents or monasteries who lack experience in performing certain tasks. In such settings, activities are often centralized and tasks assigned to certain individuals for the convenience of the community or facility, and residents may have an activity performed for them regardless of whether they have the ability to do it themselves.

There are also other situations where individuals may have had no need to, or may not have been allowed to, perform certain ADLs or IADLs. For example, some people because of socioeconomic barriers or religious beliefs, may have no experience using a telephone or driving a car. Again, unless there is also a loss of function, screeners should assume that given the opportunity and adequate training, such persons would be able to perform the task. (Note that, Family Care should be responsible for any needed training only if the individual has other functional deficits sufficient to attain a reimbursable Family Care level of care. The existence of a need for such training, in and of itself, does not necessarily mean that the needed training should be provided by Family Care. Otherwise, under that logic Family Care should provide driver education for anyone over age 18 who doesn't yet know how to drive.)

In situations where an individual is receiving assistance with an activity or has no experience in performing an ADL or IADL, a screener should:

1. Ascertain whether there are facility, communal, religious or socioeconomic reasons for an individual getting assistance or lacking experience with an activity.
2. If there are, determine whether there is any other evidence that the individual might have limited capacity to perform the function.

For example, a screener is asked to assess a nun who has taken a vow of poverty and spent her adult life in a convent. Her financial resources have always been pooled with the other residents of the convent and bills paid centrally. Money available to her personally has always been limited to a small stipend. The screener should not assume that this nun is unable to handle money and pay bills just because she never has. However, if there is evidence that she has a cognitive impairment, a screener might reasonably determine that she does indeed need help with money management. Similarly, many residents, including persons with no long-term care needs, have their meals prepared and their laundry done for them as part of their 'communal contract.' Again, the screener should not assume that the nun is unable to prepare meals or do laundry unless there is evidence that she has a physical or cognitive impairment that limits her ability to perform these functions.

# Module #5: Diagnosis

## Objectives

*By the end of this module you should be able to:*

- Accurately complete the diagnosis section of the LTC FS
- Explain how to “confirm” or “verify” a diagnoses

## 5.1 Diagnoses Must be “Verified”

Medical information is often not readily available when a screen is being done in a community setting. **To accurately complete the diagnoses section of the LTC FS, screeners must verify diagnoses and health-related services.**

**Medical information is “verified” if it is:**

1. Stated to screener by an MD, RN, or other health care professional, or
2. Copied from recent health care records, or very clearly stated -in exact words--by the person, family, advocate, etc.

Exceptions to these criteria are psychiatric diagnoses, behavioral diagnoses, and dementia. People commonly say that someone has “Alzheimer's” or “depression” without a confirmed diagnosis. So screeners must confirm those diagnoses with a health care provider or medical record.

**If diagnosis can not be verified:**

If after review of medical records and contact with health care providers it is determined that a consumer has no diagnosis, the screener should choose the “No Diagnoses” box. In addition, the screener should provide some detail regarding the absence of any diagnosis in the Notes section of the LTC FS. (Example: “after talking with Mr. Smith's doctor, it was determined that Mr. Smith has no diagnosis.”)

If an applicant refuses to see a health care professional and does not have any medical records that confirm a diagnosis, or if the person has an “old” diagnosis and refuses to see a doctor, enter this information in the Notes field of the LTC FS and explain fully. (Example: “Mr. Smith has not been to the doctor in over 30 years and refuses to be seen by a health care provider today.”)

## 5.2 Screeners Will Often Need to Contact Health Care Providers

**Often, screeners will need to contact the person's doctor's office and ask for medical diagnoses and health related services. Screeners must always have psychiatric and behavioral diagnoses confirmed by health care providers.** At the same time the screener should verify health-related services and target group information.

## 5.3 Diagnoses Table Does Not Impact Eligibility

**Completion of the LTC FS diagnoses table does no work for eligibility determination; it is for research only.** The 1999 inter-rater reliability tests on Version 1 of the screen showed an unacceptably

high rate of discrepancies among diagnoses, so they were removed from the eligibility logic. (Studies through the U.S. show poor reliability of diagnoses even among health professionals, as well as community-based settings.)

**However, the accurate documentation of diagnoses is very important to population profiles** and to show that Family Care consumers in community settings are similar to populations in facilities. As you communicate with the consumer's health care professional to accurately complete the "Health Related Services" table-which is absolutely critical in establishing accurate nursing home level of care-and the Target Group question (also critical in eligibility determination), you should confirm the diagnoses as well. (See Instructions 1.2 for more detailed information on eligibility and level of care.)

## 5.4 Completing the Diagnoses Table

**The diagnoses table is not meant to be all-inclusive; only some of the more common diagnoses are here.** This table does include almost all of the diagnoses on the MDS (Minimum Data Set) form that nursing homes must complete. It is permissible to refer to the MDS, or any other health care providers' documentation, to complete the table, but screeners must confirm that the information is still current. "Current" is defined as no more than one year ago and still applicable. **Screeners should check with health care providers to confirm that the medical information is still applicable.**

**For diagnoses, check ALL that apply.**

- For convenience, the diagnoses are grouped by major categories (e.g., Pulmonary, Cardiovascular, Neurological).

- Screeners should use the "Diagnoses Cue Sheet" provided by DHFS in order to know which box to check for a given diagnosis not listed on this table.

    - For any diagnosis not listed on the diagnoses table, first see if it is listed on the Diagnoses Cue Sheet. If it is, check the box indicated on the cue sheet. If the diagnosis is not on the cue sheet, then you can check the K5 "Other" box. Then enter the name of the diagnosis in the notes section.

    - Please note: Initial reviews of Version 2 of the LTC FS indicate that screeners are over-using the K5 "Other" box and are writing in diagnoses that are in fact already on the Diagnoses Table itself. The number of synonyms and misspellings indicate that screeners may not be contacting health care professionals to confirm the diagnoses. This calls for quality assurance and improvement efforts on the part of each Screening agency.

REMEMBER: Do not try to interpret the consumer's complaints or symptom and do not take psychiatric or dementia diagnoses at face value; they must be confirmed by health care provider.

- Example A: 82 year old Betty has diabetes and is complaining of increasingly poor vision. Screener does NOT check "Cataracts/ Glaucoma/Diabetic Retinopathy" based on this alone.

- Example B: Family says elderly father is "really losing it," and "He's getting Alzheimer's." Screener asks family if a doctor has made this diagnosis. Family said no, father hasn't been to a doctor for awhile, but "It's gotta be, he forgets so much now." Screener does NOT mark "Alzheimer's." Screener gets permission to call MD's office, and asks nurse to call back to provide diagnoses.

**If the consumer has no diagnoses, choose the "No Diagnoses" box.** See additional instructions for completing this page and the notes section under "5.1, Diagnoses Must be Verified."

*QA Checks:* The LTC FS application will check to ensure that target group selections are supported/verified on the diagnosis page. For example: "Terminal Illness" target group should be

supported by “terminal illness” on the diagnosis page, DD target group should be supported by a DD diagnosis.

# Module #6: Health- Related Services (HRS) Table

## Objectives

*By the end of this module you should be able to:*

- Explain the importance of the HRS Table to the determination of nursing home and DD level of care eligibility.
- Accurately complete the HRS Table of the LTC FS.
- Indicate when items in the HRS Table correlate well with items found elsewhere in the LTC FS.

## 6.1 Background of the Health-Related Services (HRS) Table

To be eligible for federal home and community-based waivers, a person must be eligible for a nursing facility or ICF-MR (also known as meeting nursing home or DD level of care). **The HRS table is extremely important in determining a person's waiver eligibility and Family Care eligibility (Comprehensive or Intermediate).** (See Instructions 1.2 for more information.)

## 6.2 The HRS Table and Need for Health Care Provider Consultation

Screeners are not expected to be medical or nursing experts. **Screeners should consult as needed with a health care provider in order to accurately complete the HRS table.** Screeners who are nurses may not need to consult another medical expert, but screeners who are not nurses would obtain help through one of the following methods:

- Consult with your agency nurse on completing the HRS table based on available information you have.
- Fax a health information form to the person's doctor. Ask what type of health-related services the person needs and at what frequency. Find out if they are independent with doing them.
- Talk to the person's doctor or nurse. Ask them the same questions in the above bullet.

## 6.3 Completing the HRS Table and General Rules for its Use

The HRS Table should be completed by the screener to show the presence of and frequency of each health-related service according to the instructions in this section. Some frequencies which are not applicable for a particular service have been deleted as it would not be logical to allow them to be selected (see blank areas on the following screen shot under Behaviors and Positioning).

**General Rules for the HRS Table**

- The HRS Table is designed to document people's health-related service NEEDS, not just what they are currently getting. So if a person has an HRS need, but refuses services for it or can't pay for it and isn't receiving needed services, you should still capture the need on the HRS table.
- Select the answer that most closely describes the person's need for help–whether they are actually getting that help or not.
- It does not matter who is performing the task (except for the second row where a nurse is required to perform the assessment and interventions). Families are often taught to do even very technical skilled nursing tasks.

- The table is primarily looking for “skilled nursing tasks,” primarily provided in the home. (A person’s home or “current residence” is defined in Instructions 3.15.)
- The table is NOT designed to capture acute, primary, or in-clinic services (except for dialysis, transfusions, ulcers and wound care (under certain situations), and skilled therapies). See those sections in this Module for further information.
- When more than one “frequency of help” (column) applies to one condition (row), place a checkmark to show the highest frequency (see examples provided in 6.7).
- Be sure to indicate if the person is independent, even if they are currently receiving help or services.

# HEALTH RELATED SERVICES

Check only one box per row. Leave row blank if not applicable.

| HEALTH-RELATED SERVICES NEEDED | PERSON IS INDEPEN-DENT | FREQUENCY OF HELP/SERVICES NEEDED FROM OTHER PERSONS | | | | | |
|---|---|---|---|---|---|---|---|
| | | 1 to 3 times/ Month | Weekly | 2 to 6 times/ week | 1 to 2 times a day | 3 to 4 times a day | Over 4 times a day |
| **BEHAVIORS** requiring interventions (wandering, SIB, offensive/violent behaviors) | | | | | | | |
| Requires **NURSING ASSESSMENT** (e.g., RN visits) and interventions because person is unable to self manage current health conditions or health risks. 'Unable to self-manage' means the person:<br>a. Is unable to recognize problems.<br>b. Is unable to respond to problems<br>c. Does not know contributing factors or corrective actions, **OR**<br>d. Has history of failure to self-manage health resulting in multiple ER visits or hospitalizations. | | | | | | | |
| **EXERCISES/RANGE OF MOTION** | | | | | | | |
| **IV MEDICATIONS**, Fluids or IV Line Flushes | | | | | | | |
| **MEDICATION ADMINISTRATION** (not IV). Includes assistance with pre-selected or set-up meds | | | | | | | |
| **MEDICATION MANAGEMENT** – Set-up and/or monitoring (for effects, side effects, adjustments, pain management) -- AND/OR blood levels (e.g., drawing blood sample for laboratory tests or "finger-sticks" for blood sugar levels.) | | | | | | | |
| **OSTOMY-RELATED <u>SKILLED</u> SERVICES** | | | | | | | |
| **POSITIONING** IN BED OR CHAIR every 2-3 hours | | | | | | | |
| **OXYGEN and/or RESPIRATORY TREATMENTS**: Tracheal suctioning, C-PAP, Bi-PAP, Nebulizers, IPPB treatments (does NOT include inhalers) | | | | | | | |
| **DIALYSIS** | | | | | | | |
| **TPN** (Total Parenteral Nutrition) | | | | | | | |
| **TRANSFUSIONS** | | | | | | | |
| **TRACHEOSTOMY CARE** | | | | | | | |
| **TUBE FEEDINGS** | | | | | | | |
| **ULCER – Stage 2** | | | | | | | |
| **ULCER – Stage 3 or 4** | | | | | | | |
| **URINARY CATHETER**-RELATED <u>SKILLED</u> TASKS (irrigation, straight catheterizations) | | | | | | | |
| **OTHER WOUND CARES** (not catheter sites, ostomy sites, or IVs, or ulcers) | | | | | | | |
| **VENTILATOR-RELATED INTERVENTIONS** | | | | | | | |
| OTHER (Specify): | | | | | | | |

| **SKILLED THERAPIES – PT, OT, ST** (Any one or a combination, at any location) | **5 + days/week** | **1 to 4 days/week** |
|---|---|---|
| | | |

**Coding for who will help with all health-related needs in next 8 weeks:** (Check **all** that apply.)

- ☐ **U** Current UNPAID caregiver will continue
- ☐ **PP** Current PRIVATELY PAID caregiver will continue
- ☐ **PF** Current PUBLICLY FUNDED paid caregiver will continue
- ☐ **N** Need to find new (or additional) caregiver

## 6.4 Person is NOT Independent in Managing a Health-Related Service

**If the person is not independent in performing and managing a health-related service, you place one checkmark in the column showing the most accurate frequency of "Help Needed by Another Person."** The frequency of help ranges are:

- 1 to 3 times/month
- Weekly
- 2 to 6 times/week
- 1 to 2 times/day
- 3 to 4 times a day
- Over 4 times a day

The definitions for each condition (each row) will list the "skilled" tasks that you are to focus on, and in some cases tell you which tasks to ignore. For instance, in the rows for urinary catheter, you are to ignore the unskilled tasks like emptying the bag, and only consider the skilled tasks (replacing the catheter, irrigating it).

When more than one "frequency of help" (column) applies to one condition (row), place a checkmark to show the highest frequency (see examples provided in 6.7).

## 6.5 Person is INDEPENDENT in Managing a Health-Related Service

**If the person is completely independent in doing the tasks and managing a health-related service, place a checkmark in the column to show that "Person is Independent."** There should be **no frequency checked** at which the person needs help from another.

Be careful not to overlook help provided by informal supports. Sometimes consumers appear independent with tasks, but in reality they are receiving supports (such as telephone cues to take meds twice a day).

**Be sure to indicate if the person is independent, even if they are currently receiving help or services.** The HRS Table is designed to document people's health-related service NEEDS, not just what they are currently getting.

> Example: Amy is currently in the hospital but will soon be discharged. She has the physical and cognitive ability to manage and administer her own medications. However, hospital policy requires that all medications are managed by hospital staff for all patients. Screeners should indicate that Amy is independent with med management and administration, even though she currently receives help from the nurse.

## 6.6 Person is INDEPENDENT in some tasks, but NOT Independent in Others

In many cases, the person is independent in some tasks, but needs help from another person with other tasks related to the same condition (i.e., in the same row of the HRS table). **Pay attention to the column heading that shows that the frequencies are "Frequency of help/services needed from other persons."**

Example: Inez does her own ankle dressing for a wound twice a day. But Inez can't see well and can't judge if it's getting worse or better. A nurse examines it once a week to be sure it's healing well and to adjust the wound care as needed. Inez calls the nurse if she has any problems in between. You mark "Weekly" for the "frequency of help/services needed from other persons." Be careful not to mark the twice a day task that Inez does independently under the heading for help from other persons.

## 6.7 Indicate Frequency of Skilled TASKS, Not Duration of Condition

**For conditions that are continually present** (e.g., a permanently placed urinary catheter), **your checkmark should indicate the frequency of tasks related to the health-related service. When one HRS involves more than one task, check the most frequent task with which help is needed from others.**

Example: Bob has a permanently placed urinary catheter. The catheter is changed (by a nurse) every 30 days. Daily "cath care" is just soap and water as normal part of bathing and is not really considered a "health-related service" on this table. No other care is needed. Bob also has a tracheostomy. Tasks related to this include having a nurse change the trach tube once every month, and an aide clean the trach site ("trach care") twice a day. He is generally self-directing and stable and visits his doctor's office only once every 4 to 6 months.

The screener should place TWO checkmarks on the HRS table: 1) Urinary catheter-related skilled tasks at "1 to 3 times/month" and 2) Tracheostomy Care at "1-2 times/day."

### Instructions for Particular Health-Related Services

## 6.8 Interventions Related to Behaviors

**Definition**: These types of interventions include monitoring and having someone present to prevent a behavior in someone with a cognitive impairment, as well as more direct interventions such as redirecting the person, physically preventing the behavior and responding to problems caused by the behavior.

**Use This Row When**:

- Behavior interventions are required for wandering, head-banging, or impulsive behavior that has a negative effect on the person's health (e.g., a person with organic brain syndrome and cognitive deficits, who given the opportunity drinks heavily).
- A person with a severe mental health diagnosis has thought processing problems that create behavior issues requiring a plan and interventions (i.e., a person with a severe personality disorder who requires a behavior plan for safety).
- There is a formalized plan developed to manage and contain behaviors. This plan could be developed by a psychiatrist, psychologist, behavior specialist, interdisciplinary team, or family. These types of plans typically involve the use of professional or non-professional caregivers, medications or restraints.

  **Example 1** – Situation where behavior problem is unpredictable:
  An elderly woman with advanced Alzheimer's is being cared for at home by her family. Due to her dementia she becomes extremely agitated when confused. The family has developed a formalized plan to deal with these behaviors which include:

  a.) Extreme agitation is exhibited.
  b.) Every time this happens the same intervention is provided.
  c.) Intervention is that a family member re-directs the woman by sitting her on couch and reviewing family photo album, names, and experiences.
  d.) Woman is calmed and agitation abates.

The family makes sure everyone knows about this plan and knows what to do when her agitation starts, and knows where the photo album is.

**Example 2 – Situation where behavior is predictable and interventions are provided to prevent the predictable behavior**:
A young man with a developmental disability has a water addiction. He needs an intervention whenever he heads for the water faucet; this is most likely to occur after meals. The facility has developed a formalized plan to deal with these behaviors which include:

a) The behavior plan starts immediately after meals.
b) The staff where he lives distract him away from the water.
c) They do this three times each day. His records show that he manages to get to the water about two times each week.

~~Behavior interventions are required for wandering, head-banging, or impulsive behavior that has a negative effect on the person's health (e.g., a person with organic brain syndrome and cognitive deficits, who given the opportunity drinks heavily).~~
~~A person with a severe mental health diagnosis has thought processing problems that create behavior issues requiring a plan and interventions (i.e., a person with a severe personality disorder who requires a behavior plan for safety).~~

**Do NOT Use This Row**:

- For someone without a cognitive impairment or thought processing problem.
- For sporadic, unpredictable crisis-oriented interventions, such as those involving law enforcement.
- When there is not a formalized plan to manage and contain behaviors.

  Example: An elderly woman with advanced Alzheimer's is being cared for at home by her family. Due to her dementia she becomes extremely agitated when confused. The family has not developed any consistent or formalized plan to deal with these behaviors. It depends on who is taking care of her. There has been no attempt to pass on or formalize what works, and each caretaker approaches it differently. One family member will deal with the extreme agitation by trying to reason with her and use logic. Another family member will give her ice cream. Another one tries to ignore the behavior. The elderly woman's agitation fluctuates day to day and episodes seem to get worse over time.

- For interventions required that are related to court orders or AODA services such as AA.
- If someone requires custodial care not interventions, or acts of omission such as self-neglect (which can be indicated in the Risk Module 9.1).

**How to Determine the Frequency**: If the person requires interventions related to behaviors select the frequency according to the guidelines detailed in section 6.4.

- For example 1 (above) record the average frequency of interventions provided according to the family.
- For Example 2 (above) record three times/day on the behavior row since that is the frequency interventions are provided.

**Tip**: Other sections of the LTC FS that should correlate with this row are "Offensive or Violent Behaviors," "Physically Resistive to Care," "Wandering," and "Self -Injurious Behaviors." To ensure accuracy, the LTC FS programmed logic will warn you, the screener, when these items do not correlate.

## 6.9 Nursing Assessment and Interventions

**Definition**: A community-based nurse (e.g., public health, home health, care management team, or residential-facility nurse) provides assessment and interventions for a person to help manage a current health condition or health risk. Assessment is the systematic and continual collection and analyses of

data about the health status of a patient. Intervention is the nursing action to implement the plan of care by directly administering care or by overseeing delegated acts.

Information needed for the assessment can be gathered by a non-skilled person such as a Certified Nursing Assistant, family member, or even the person themselves and provided to the nurse. At times the community-based nurse may provide management related to this row over the phone to the person if an in-home visit does not occur.

**Use This Row When**:

- The person is unable to self-manage current health conditions or health risks. "**Unable to self-manage," means the person**:
  a) Is unable to recognize problems;
  b) Is unable to respond to problems;
  c) Does not know contributing factors and corrective actions; **OR**
  d) Has a history of failure to self-manage health resulting in multiple ER visits or hospitalizations (inpatient or out-patient).

- The person is "unable to self-manage" due to cognitive impairment, lack of training, or due to illness and fatigue. Any of these factors impact the person's ability to focus on and mange their condition.

  Example of someone who requires a Nursing Assessment: An elderly consumer is falling a lot. She knows she's falling, and can call 911 if she needs to, but she requires nursing assessments and interventions to figure out why she's falling and how to prevent falls.

- The person requires nursing assessment and interventions due to severe pain.

  For example: A person with severe pain due to arthritis goes to a pain clinic once a week for ultrasound treatments and biofeedback sessions. In the home, a nurse assesses the effectiveness of the medication regimen once/month and works with the person on relaxation strategies monthly. Count the frequency of the nursing assessment in the home but don't include the trips to the clinic.

**Do NOT Use This Row**:

- If the person's only need is for health education or counseling by a nurse. Remember, the HRS table is used to determine whether the person is nursing home eligible. Nurses could educate or counsel almost anyone, but that does not mean the person is nursing home eligible. The person is nursing home eligible only if they need skilled assessment, monitoring, and interventions because they are unable to self-manage current health conditions or health risks.

  Example of someone who does **NOT** require a Nursing Assessment: A woman is "at risk" for clots or strokes due to post-menopause and high blood pressure. However, she is able to self-manage this condition. She monitors her blood pressure at home and calls her doctor if it is too high.

- **Based on agency or nurse habit**, e.g., doing monthly visits to check on the person. Use of this row should be based on what the person needs, not what the nurse is doing as part of agency routine.

- For nursing tasks provided in a primary care setting.

- For social worker tasks that do not require the skills of a nurse or are not part of the nursing process.

- **If other rows already include all of the nursing assessment and interventions that the person needs**. In other words, do not "double dip" and use two rows when you should only use one. For example, if you checked a frequency of interventions for wound care, and the person

has no other “skilled nursing” needs, then do not check this row for “Needs Nursing Assessment” as well.

Example of when not to “double dip:” Inez does her own ankle dressing for a Stage 2 Ulcer wound twice a day. But Inez can't see well and can't judge if it's getting better or worse. A nurse examines it once a week to be sure it's healing well and to adjust the wound care as needed. Inez calls the nurse if she has any problems in between. Inez has no other health-related services.

Check “Weekly” for the “frequency of help/services needed from other persons” on the “Ulcer Stage 2” row. Leave the “Requires Nursing Assessment” row blank because the nurse’s assessment of Inez’s ulcer is already captured under the “Ulcer Stage 2” row.

**How to Determine the Frequency**: If the person requires nursing assessment and interventions because they are unable to self-manage a condition, select the frequency according to the guidelines detailed in section 6.4. Include in the count toward frequency the instances of information gathering. For example, to help manage a heart condition the person is weighed **each day** and if their weight goes up more than 3 pounds, the community-based nurse is called. Record the frequency for nursing assessment at 1-2 times a day. Make sure the person meets criteria a-d (above) under “unable to self-manage” as applicable.

**Tip**: If the LTC FS elsewhere describes a high-functioning person with no cognitive impairments (e.g., someone who drives or works full-time without assistance), it would appear that they could monitor their own health conditions and this row should not be checked. This element in the HRS table will be monitored by DHFS at regular intervals and cases will be referred to screen leads as necessary for follow-up.

## 6.10 Exercises/Range of Motion

**Definition**: This row reflects exercising and/or performing “range of motion” exercises to promote or maintain muscular function. The person is at risk for loss of muscular function due to a health condition. The person may perform these exercises themselves or family or staff may help perform them. The exercise program may or may not have been set up by a rehabilitation therapist and helpers may or may not have been trained by the therapist.

**Use This Row When**:

- The person is engaging in exercises to prevent loss of function and maintain muscular tone. For example, after a stroke a person receives “range of motion” exercises to their affected side three times a day to promote muscular function lost.

**Do NOT Use This Row**:

- If the exercises are being performed by a rehabilitation therapist. Instead, use the “Skilled Therapy” row at the bottom of the HRS table (described in section 6.27).

**How to Determine the Frequency**: The person may be independent in this activity or they may need help from another for this task. Depending on the situation, select the frequency according to the guidelines in section 6.4 or 6.5.

## 6.11 IV Medications, Fluids or IV Line Flushes

**Definition**: “IV” stands for intravenous, and intravenous pertains to medications, fluids or flushes delivered within or into a vein. This may consist of IV injection or IV infusion. Most common are small bags of antibiotics that “drip” in (usually via an IV pump for safety).

**Use This Row When**:

- IV medications, fluids or IV line flushes are provided in the home.

- The person requires IV medicine, like an antibiotic to drip into their vein to treat a serious infection. IV medications usually drip in over 30 to 60 minutes.

- The person requires IV fluids because they are unable to consume enough liquids and are dehydrated. Typically these fluids consist of "normal saline" or weak solutions of "dextrose" which are given for acute dehydration or until tube feedings can be established.

- The IV is "flushed," which means irrigating or washing out with a bit of sterile solution or medication, and flushing is the only IV intervention being provided. Don't count flushing separately if it's part of one intervention that combines several tasks (e.g., starting the med, flushing, and disconnecting).

- "Site cares" are provided, such as cleaning and re-bandaging the IV site. Site cares usually occur every few days, but it depends on what the doctor has ordered.

**Do NOT Use This Row**:
- For IV services provided outside the home (i.e., in a primary care setting such as a clinic).
- For TPN, which has a separate row (see section 6.18).

**How to Determine the Frequency**: In most cases, IV medicines drip in over 30 or 60 minutes, which is essentially one visit by a nurse; this can be called one intervention even though it combines several tasks (starting the med, flushing and disconnecting afterwards). Mark the frequency of interventions needed, not the frequency of med administration.

> Example: Many times a computerized IV pump delivers a med three times a day, but the IV only needs to be set up (refilled and re-programmed) every two or three days. In between sets-ups, the IV works fine and the consumer/family know how to handle problems and when to contact the nurse. You'd check the "2 to 6 days a week" column for the set-up every 2 to 3 days.

**Mark the frequency of interventions needed, not just administration of fluids**. For instance, starting an IV infusion in the p.m. and disconnecting it in the a.m. equals two tasks.

For additional guidance in determining the frequency for this health-related service, refer to section 6.4.

## 6.12 Medication Administration (not IV) or Assistance with Pre-Selected or Set-Up Meds

**Definition**: This row is about a person taking or being given a medication by any route except IV. This could be by mouth or under the tongue, by an injection, or rectally or vaginally. Sometimes a person just needs assistance in taking the medication and that activity is captured on this row as well. Use of medication that is regularly scheduled, not "as-needed" meds, should be captured here. (If the person is unable to self-manage the use of "as-needed" medicine, they may qualify for checking the nursing assessment row if all criteria there is met). The type of regularly scheduled meds can be brand name, generic, or over the counter (OTC). If the person takes no regularly scheduled medication then this row is not applicable.

**Use This Row When**:
- The person takes regularly scheduled meds. If the person can take medications independently, check the "Person is Independent" column. If the person needs someone to give them their medications, there are three general possibilities that are included under this row:

    1. **Med Administration**: This is a skilled task in which the nurse or someone trained by a nurse administers the meds. Administration includes selecting the proper med and dosage and being able to judge whether a medicine should be taken or withheld due to symptoms or side effects.

2. **Assistance with Pre-Selected Meds**: An unskilled person (without the judgment about giving or holding a med) can "assist" with medications that have been "pre-selected" – that is, the proper med and dosage have been selected in advance by a pharmacist, a nurse, or someone trained by a nurse. Qualifying assistance here could include a son calling his elderly mother to remind her to take her medications. Instances as verbal cueing count as Medication Administration.

3. **Assistance with Self-Medication**: This is when a self-directing consumer has the cognitive ability to select the proper med and dosage and the judgment to understand the medications' purpose and side effects and to report problems, but needs someone to physically assist with the medicine. This includes the person with quadriplegia who instructs a personal assistant to help him with this meds under his close direction.

**Do NOT Use This Row**:
- If the person is given medication by IV only. This is captured on the IV Medication row (see 6.11).
- If the person only takes "as needed" medications (e.g., aspirin or ibuprofen for occasional headaches).

**How to Determine the Frequency**: Use the Independent column if the person can take all their meds themselves without any help. If they need someone to give them their meds or some form of assistance, mark the frequency column according to the guidelines in section 6.4.

## 6.13 Medication Management: Set-up and/or Monitoring Meds (for Effects, Side-Effects, Adjustments, Pain Management) and/or Blood Levels

**Definition**: Use of this row reflects that a person's regularly scheduled meds require management of some form. Examples include that they need to be set-up in a pill box each week, or side effects or efficacy need to be monitored, or that blood levels for lab tests relating to the medication needs to be drawn in the home. It could also be for blood draws not strictly related to medications when drawn in the home.

**Use This Row When**:
A person has regularly scheduled meds which require management of some sort. Examples of med management activities include:

1. **Medication set-up, such as**:
   - "Bubble-packs" from a pharmacy.
   - "Pill boxes" or "med boxes" with compartments labeled for different times and each day of the week, into which a nurse or other trained person places the pills that are to be taken at those times on those days.
   - Any other "set up" system in which meds and dosages are pre-selected which includes daily pre-selections for someone unable to both self-administer, identify correct dosage, and monitor effects.
   - Medication dispensing machines that can be programmed (often weekly) to dispense pills.
   - Pre-filling of syringes (most commonly insulin syringes).

2. **Medication Monitoring**
   This is monitoring for the effects and side-effects of medicines. It includes reporting such information to the prescribing physician or nurse practitioner and making changes as prescribed by them. For example, adjusting insulin, coumadin, or anti-hypertensive medication. Or a person may have an internal morphine pump that might require monitoring in the home to determine if the amount of medication released is effective.

3. **Pain management**
   This includes adjusting meds in order to manage pain. This does not include chiropractic care, care at a pain clinic, or non-prescription meds, e.g., an occasional Tylenol for arthritis.

4. **Blood levels**
   Includes drawing blood samples for laboratory tests. The majority of these are related to medications (e.g., Pro-Times to regulate Coumadin administration, or potassium levels for a person on diuretics). Other blood draws not strictly related to medications can be included here as well, such as CBC (complete blood count) or Creatinine (to check kidney function). Blood levels also includes "finger-sticks" for capillary blood to test blood sugar levels.

Sometimes it is difficult for screeners to decide if the medication administration row applies, or the medication management row, or that possibly both rows apply. However, it's important to use either or both of these rows as they apply to the person in order to capture any eligibility weight attached to the activity.

**The following section provides examples when to use the Medication Administration and/or Medication Management rows on the HRS table.**

CASE #1:You would use the Medication Administration column to capture when a person is independent with his/her insulin injections or the use of an insulin pump. If the person is doing their own blood sugar checks, you would also put a checkmark in the left-most column ("person is independent") in the row for Medication Management.

CASE #2: If the person is independent with their insulin but needs someone else to set up their pills, you would mark the left-most column ("Person is independent") in the row for Medication Administration, to reflect that she takes her own insulin and her own pills. In the row for Medication Management you check the frequency at which someone must set up the pills.

CASE #3: In the case where someone is "cheeking" his/her medicine (hiding it in their cheeks and not swallowing it), you would mark the frequency at which someone assists with either Medication Administration or Medication Management or both. Most of the time when someone is cheeking her/his meds it is because of mental illness or other cognitive impairment, and they are already having someone assist them with their meds.

CASE #4: If the person takes their medication themselves out of the bottles and require no other medication management services such as med set-up, then just use the Medication Administration row.

CASE #5: If the person requires a monthly blood draw at home for a complete blood count but takes no medication, then just use the Medication Management row.

**Do NOT Use this Row**:

- For blood draws done outside the home (i.e., in a primary care setting such as a clinic).
- If an internal morphine pump does not require monitoring for effectiveness in the home, but only intermittent re-fills and maintenance in the clinic setting.

**How to Determine the Frequency**: Use the Independent column if the person can manage all of their meds themselves without any help. If they need help from another person with any of the medication management activities, mark the frequency column according to the guidelines in section 6.4.

**Tip**: The LTC FS application will check to ensure that the level of help indicated in the Medication Management IADL (discussed in Module 4) correlates with the Medication Administration and Medication Management rows in the HRS Table. If the level of help does not correlate between the Medication Management IADL and the Medicaid Administration and Medication Management rows, the screener will receive an error message to prompt correction.

## 6.14 Ostomy-Related Skills Services

**Definition**: An ostomy is a surgically created opening in the body for the discharge of body wastes. There are several different types of ostomies, e.g., colostomy: opening in the colon; ileostomy: opening in the small intestine; urostomy: opening in the bladder.

Use of the row reflects that skilled tasks are being provided to an ostomy site or opening.

**Use this Row When**:

- Ostomy-related skilled services are being done. "Skilled" tasks include changing the wafer (which adheres to the skin and needs to be cut to proper size to avoid skin breakdown around the ostomy), doing site care (skin around the ostomy, where the wafer will attach), and irrigations. Wafer changes and site care is usually done only once every 7 or 10 days for a stable ostomy, but much more frequently for a new ostomy or one with problems like leaking and skin breakdown.

**Do NOT Use this Row**:

- For ostomy-related skilled services provided outside the home (i.e., in a primary care setting such as a clinic).
- For the unskilled task of emptying the ostomy bag.

**How to Determine the Frequency**: Use the Independent column if the person can manage all of their ostomy-related skilled services themselves. If they need help from another person with any of these tasks mark the frequency column according to the guidelines in section 6.4.

## 6.15 Positioning in Bed or Chair Every 2-3 Hours

**Definition**: Positioning means a person is moved to redistribute pressure applied to the body. Changing a person's position is a preventive measure to help avoid bedsores and pneumonia. Positioning is not a skilled task, but was added to the HRS table at the request of the screeners.

**Use this Row When**:

- The person needs to be positioned by another at least every 2-3 hours.

**Do NOT Use this Row**:

- If the person can position independently.
- If the person need to be positioned less than 3-4 times/day.

**How to Determine the Frequency**: No frequency column applies to this activity except "3-4 times a day" or "over 4 times a day." If the person is positioned by another every day, pick either of these columns which best describes that frequency.

**Tip**: The Bathing, Dressing, Mobility, Toileting and Transferring ADLs of the LTC FS should be checked as a need as appropriate to correlate with any need for positioning in bed or chair. To ensure accuracy, the LTC FS programmed logic will warn you, the screener, when these items do not correlate.

## 6.16 Oxygen and/or Respiratory Treatments: Tracheal Suctioning, BI-PAP, C-PAP, Nebulizers, IPPB Treatment (Does NOT include inhalers)

**Definition**: Use this row to reflect the use of oxygen or provision of respiratory treatments as defined below:

- **Oxygen**: Some people with asthma, emphysema, chronic bronchitis, occupational lung disease, lung cancer, cystic fibrosis, or congestive heart failure use oxygen at home to treat their oxygen

deficiency. Three common ways of providing it are by compressed gas, liquid oxygen, or by an oxygen concentrator. Three common means of delivery are nasal cannula, a mask, or tran-stracheal (a flexible catheter inserted into the trachea or windpipe).

- **Tracheal Suctioning**: If a person has a tracheostomy (an artificial opening into a trachea or windpipe) they may require suctioning of this area to clear secretions.

- **Bi-PAP and C-PAP**: These terms mean that positive airway pressure is provided via a mask to maintain adequate oxygen delivery or to alleviate an excessive breathing workload.

- **Nebulizer**: This is a device that uses pressurized air to turn liquid medication into a fine mist. The pressurized air typically comes from a portable pump unit that internally consists of a motor-driven air pump that resembles the fancier types of aquarium pumps. It forces air through a plastic tube into the plastic nebulizer unit. Inside, the nebulizer unit acts much like a perfume atomizer, creating a fine mist that is directed either through a tube that is inhaled through or a mask that directs the mist into the nose and mouth.

- **IPPB Treatments**: "IPPB" stands for intermittent positive pressure breathing. This is a technique used to provide short-term or intermittent mechanical ventilation by way of a pressure-cycled ventilator. This type of treatment is used to expand the lungs, deliver aerosol medication, or assist ventilation.

**Use this Row When**:

- The person is using oxygen or requires respiratory treatments as defined above. If the person is on some other form of respiratory treatment such as chest physiotherapy and postural drainage you can also use this row.

**Do NOT Use this Row**:

- To record the oxygen vendor's trips (usually every few weeks) to provide new oxygen tanks.
- For hand-held inhalers or aerosols, which have pre-metered doses. (If the person needs help with those, include them on the Medication Management/Medication Administration rows.)
- If a person needs to use a mechanical volume ventilator (see section 6.26).

**How to Determine the Frequency**: Determine if the person is independent or not with their oxygen and/or respiratory treatments. Special consideration to cognitive functioning must be applied if oxygen is used. For example:

> Oxygen is often worn continually; screeners should find the frequency at which the person needs help from others with particular tasks related to the oxygen. If the person is independent in oxygen and/or respiratory treatments such as turning the oxygen on and off, taking it on and off, checking their oxygen saturation level, and changing water bottles and tubing, then check the column for "Person is Independent." If a person with Alzheimer's or dementia requires oxygen, examine the level of help required from others. Do not list the person as "Independent."

If the person does need some level of help, mark the frequency according to the guidelines in section 6.4. If the person is not independent in certain treatments which vary in frequency, check the number of times on average that the person needs them.

## 6.17 Dialysis

**Definition**: Dialysis artificially filters and removes waste products and excess water from the blood, a process normally performed by the kidneys. There are two types of dialysis – hemodialysis and peritoneal dialysis. Hemodialysis is where an external machine cleans the blood. Peritoneal dialysis is where the person's abdominal cavity is used to filter the blood.

**Use this Row When**:

- The person is undergoing dialysis at home **OR** in a clinic. This row is an exception to the rule that HRS tasks recorded must be only those provided in the home.

**Do NOT Use this Row**:

- To capture transportation to the dialysis clinic; transportation is captured as an IADL.

Be careful to avoid "double dipping" here. Only also use the "Requires nursing assessment" row (in addition to the dialysis row) if the person is very unstable at home (or has other problems) and meets all the criteria for unable to self-manage as required to use the nursing assessment row.

**How to Determine the Frequency**: If the person is receiving hemodialysis, capture the frequency of dialysis clinic visits. Usually these are three times a week. Most people receive this type of dialysis.

If the person is undergoing peritoneal dialysis, this usually occurs overnight in the home. The person is often independent with this task, or they could have a nurse or family member assisting.

**Count hooking up and disconnecting as two separate tasks**. So, if a person has overnight peritoneal (through the abdomen) dialysis and requires help from another with this procedure, it counts as two tasks (hooking up and disconnecting) at a minimum.

## 6.18 TPN (Total Parenteral Nutrition)

**Definition**: This is a type of liquid nutrition that is administered through an IV. It supplies all of the person's daily nutritional requirements and is used when the person cannot eat, or cannot get enough nutrients from the foods they eat. It is always administered through an IV pump to precisely control the infusion rate.

**Use this Row When**:

- The person is receiving TPN at home.

**Do NOT Use this Row**:

- If the person is receiving tube feedings (described in section 6.21). That is a different type of supplemental nutrition.

**How to Determine the Frequency**: Use the independent column if the person can manage their TPN themselves. If they need help from another person mark the frequency column according to the guidelines in section 6.4.

Sometimes TPN runs into the person continuously. If this is the case **and** they need help from another to "hook up" a new bottle or bag of liquid, mark the frequency this hook-up occurs – usually 3-4 times a day.

## 6.19 Transfusions

**Definition**: This means that blood or one of its components, such as red blood cells or platelets, is delivered into a person's blood stream. The blood or blood product is delivered through an IV.

**Use this Row When**:

- The person receives transfusions at home OR in a clinic. This row is an exception to the rule that HRS tasks recorded must be only those provided in the home.

**Do NOT Use this Row**:

- Unless the person requires this service as defined above.

**How to Determine the Frequency**: A skilled health care provider would need to administer a transfusion. Use of the independent column would not be applicable here. If the person receives transfusions at a clinic or at home, check the frequency column according to the rules in section 6.4.

## 6.20 Tracheostomy Care

**Definition**: If a person has a tracheostomy (an artificial opening into a trachea or windpipe) they will require what is known as "tracheostomy cares." These cares include cleaning the tracheostomy site, changing the tracheostomy tube, and changing the straps or ties which hold the tube in place.

**Use this Row When**:

- A person requires tracheostomy cares as defined above.

**Do Not Use this Row**:

- For tracheostomy care provided outside the home (i.e., in a primary care setting such as a clinic).

**How to Determine the Frequency**: Use the independent column if the person is able to do their trach cares themselves. If they need help from another person with any or all of the tasks, check the frequency of the most frequently done task. For example, the trachea tube is changed once a month and site care is done by another twice a day. The screener should put a checkmark in the 1 to 2 times a day column.

## 6.21 Tube Feedings

**Definition**: Sometimes people with an illness or injury have trouble swallowing or are not alert enough to eat. If they cannot eat or cannot eat safely to obtain adequate nutrition, a feeding tube is placed in the body to give the needed nutrition.

There are several different locations where a feeding tube can be placed on a person's body. The name of the type of tube matches the location. The types of tubes are:

- NG (Nasogastric): A feeding tube down the nose (or mouth) and esophagus to the stomach. (Rare and temporary, due to risk of aspiration into lungs and discomfort in nose and throat).
- G-tube (Gastrostomy): Tube goes through the abdomen into the stomach.
- J-tube (Jejunostomy): Tube goes through the abdomen into the intestine just below the stomach.

**Use this Row When**:

- The person requires tube feedings as defined above.

**Do NOT Use this Row**:

- For tube feedings done outside the home.
- When the person can eat without any problems and a G-tube is only used to administer medication. In this circumstance flushing the tube after giving the meds is not captured on this row, but as part of the med administration row. The only task to capture in this type of circumstance is changing the G-tube every 30 days or so.
- For TPN which is given through an IV/vein. That is a different type of supplemental feeding (see section 6.18).

**How to Determine the Frequency**: Sometimes a person can be independent with some steps of the tube feeding like administering it or caring for the skin around the tube. Changing the feeding tube must be done by a skilled health care provider.

You do not need to separate out every single task if several are done at the same time. Instead, **indicate the general number of times a day that the tube feeding is changed, started, stopped, etc.** If they are fairly independent with tube feeds, they might only need help from another person every 30 days or so to change the tube.

If the person is on continuous tube feeding and needs help from another person with everything, the tasks (checking for placement, starting a new bag of feeding, etc.) are most often done "over 4 times a day" and you should indicate that frequency.

## 6.22 Ulcer - Stage 2

**Definition**: If a person has a sore area that's classified as an "Ulcer-Stage 2" this means that the areas has partial-thickness skin loss, presenting superficially as an abrasion, blister, or small crater. This is only the very beginning of skin breakdown. This breakdown occurs due to external and internal factors and commonly occurs on the area above the tailbone, elbows, heels, hips, ankles, shoulder and back.

**Use this Row When**:

- A person has been diagnosed as having an "Ulcer-Stage 2" and special wound care for it is being done. Special care will include wound cleansing and wound dressings.

**Do NOT Use this Row**:

- For routine skin care or only when band-aids are used.
- For Ulcer-Stage 2 wound care provided outside the home UNLESS skilled services for this condition cannot be provided in the home. You can use this row for health-related services provided in a clinic setting under certain circumstances.

  Example: The person requires treatments for this condition which are complex in nature. Local home health agencies cannot provide the needed cares due to the complexity and cost, and no family member is available to perform the needed care. The person must be transported to an area clinic/wound clinic to receive needed cares because they cannot be provided in the home. Under these circumstances this row maybe used for services provided in a clinic setting.

**How to Determine the Frequency**: The person may be independent in this activity or they may need help from another for this task. Use the independent column if the person can do the special wound care themselves. If they need help from another, mark the frequency column according to the guidelines in section 6.4.

Example: Inez does her own ankle dressing twice a day. A nurse examines it once a week to be sure it's healing well and to adjust the wound care as needed. Inez calls the nurse if she has any problems in between. You mark "Weekly" for the "frequency of help/services needed from another person". Be careful not the mark the twice a day task that Inez does independently under the heading for help from another person.

## 6.23 Ulcer-Stage 3 or 4

**Definition**: If a person has a sore area that's classified as an "Ulcer-Stage 3 or 4," this means that there is more extensive damage to the area than is seen in a Stage 2 ulcer. A Stage 3 ulcer has full thickness skin loss, and presents as a deep crater with or without undermining of adjacent tissue. A Stage 4 ulcer has full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone or supporting structures. These types of sores occur due to external and internal factors and commonly occur on the area above the tailbone, elbows, heels, hips, ankles, shoulder and back.

**Use this Row When**:

- A person has been diagnosed as having an "Ulcer-Stage 3 or 4" and special wound care for it is being done. Special care includes wound cleansing and wound dressings.

**Do NOT Use this Row**:

- For Ulcer-Stage 3 or 4 wound care provided outside the home UNLESS skilled services for this condition cannot be provided in the home. You can use this row for health-related services provided in a clinic setting under certain circumstances.

Example: The person requires treatments for this condition which are complex in nature. Local home health agencies cannot provide the needed cares due to the complexity and cost, and no family member is available to perform the needed care. The person must be transported to an area clinic/wound clinic to receive needed cares because they cannot be provided in the home. Under these circumstances this row maybe used for services provided in a clinic setting.

**How to Determine the Frequency**: The person may be independent in this activity or they may need help from another for this task. Use the independent column if the person can do the special wound care themselves. If they need help from another, mark the frequency column according to the guidelines in section 6.4. You can also refer to the example in section 6.22 for help in determining the frequency.

## 6.24 Urinary Catheter-Related Skilled Tasks (Irrigation, Straight Caths)

**Definition**: A urinary catheter is any tube system placed in the body to drain and collect urine from the bladder. A health care provider will recommend use of the catheter for short-term use or long-term use. Short-term use is also known as "straight caths" or "intermittent urinary catheterizations" and are an "in and out" cathing, usually done every 4 or 8 hours. Long-term use is also known as an "indwelling" catheter that is left in place for a period of time and is connected to a drainage bag.

**Use this Row When**:

- Skilled tasks relating to the care of a urinary catheter are done. Skilled tasks include changing (replacing) the catheter, and irrigating the catheter (done for infections and if catheter tends to get clogged with sediment) or doing an "in and out" cathing.
- "Site care" is provided to a suprapubic catheter (one which goes in through a small hole in the skin just above the pubic bone). "Site care" means that special care is given to the area where the catheter goes into the abdomen. "Site care" is usually cleansing this area with soap and water and covering with a dry gauze.

**Do NOT Use this Row**:

- For routine "cath care" for an indwelling catheter – this is usually just soap and water as a normal part of bathing. Do not confuse "site care" for a suprapubic catheter with "cath care" for an indwelling catheter.

**How to Determine the Frequency**: If the person has been taught how to do their own urinary catheter skilled tasks themselves, mark the independent column. If they need help from another with any skilled urinary catheter tasks, mark the frequency column according to the guidelines in section 6.4.

Examples:

- If a person can do their own intermittent catheterizations, mark the independent column.
- If a nurse needs to change an indwelling catheter every 30, 60 or 90 days, check the 1-3 times per month column.
- If an indwelling catheter is just used at night, putting it in and taking it out counts as two separate tasks if done by another. Mark the 1-2 times a day column.

**Tip**: If urinary catheter related skilled tasks is checked on the HRS Table, then the Toileting ADL adaptive equipment "catheter" should match. To ensure accuracy, the LTC FS programmed logic will warn you, the screener, when these items do not correlate.

## 6.25 Other Wound Cares (Not cath sites, ostomy sites, IVs or Ulcer Stage 2, 3, or 4)

**Definition**: Use of this row means a person needs wound care from a serious burn, traumatic injury or serious infection.

**Use this Row When**:

- The person needs special wound care caused by any of the problems listed in the above definition. Special wound care includes wound cleaning and wound dressing.

**Do NOT Use This Row**:

- For catheter sites, ostomy sites or IVs.
- If it only involves changing Band-Aids.
- If you already checked "Ulcer-Stage 2" or "Ulcer-Stage 3 or 4" because that is a different type of wound care. Use this row only if the person has other wounds as described in the definition above.
- For wound care provided outside the home UNLESS skilled services for this condition cannot be provided in the home. You can use this row for health-related services provided in a clinic setting under certain circumstances.

    Example: The person requires treatments for this condition which are complex in nature. Local home health agencies cannot provide the needed cares due to the complexity and cost, and no family member is available to perform the needed care. The person must be transported to an area clinic/wound clinic to receive needed cares because they cannot be provided in the home. Under these circumstances this row maybe used for services provided in a clinic setting.

**How to Determine the Frequency**: The person may be independent in this activity or they may need help from another. Use the independent column if applicable. If they need help from another, mark the frequency column according to the guidelines in section 6.4.

If the person has more than one treatment or more than one wound, put one checkmark to show the highest level of help needed if applicable.

## 6.26 Ventilator-Related Interventions

**Definition**: A ventilator (also known as a respirator) is the equipment used to mechanically assist breathing by delivering air to the lungs. A ventilator can take over the act of breathing completely or assist weakened respiratory muscles. Use of the ventilator can be short-term or long-term, depending on the individual's medical needs and condition. Use of this row means the person needs to use a mechanical volume ventilator.

**Use this Row When**:

- The person uses a ventilator as defined above.

**Do NOT Use this Row**:

- If the person uses a "C-PAP" or "Bi-PAP" (record this on the oxygen/respiratory treatments row).

**How to Determine the Frequency**: If the person can self-mange their ventilator, check the independent column for frequency.

Example: Many part-time or nocturnal ventilator users live independently.

Often people with ventilators require very frequent help and interventions around the clock. If that is the case, mark the frequency column according to the guidelines in section 6.4.

Example: Some ventilator users are totally dependent and require nurses or attendants around the clock who are trained in the use of the equipment and secretion removal techniques.

## 6.27 Skilled Therapies: PT, OT, ST (Any one or a combination, at any location)

**Definition**: Use of this row reflects that the person is receiving services from a skilled rehabilitation therapist. These therapists provide the following services:

- **Physical Therapist (PT)**: A physical therapist helps with the body's recovery after a patient's accident or illness. The physical therapist helps with muscle strength, movement of the joints and more complicated body skills such as sitting, walking and balance, or the use of a walker or wheelchair.

- **Occupational Therapist (OT)**: An occupational therapist helps the patient regain everyday skills that might have been lost because of an injury or illness. The occupational therapist will help with everyday activities like eating, brushing teeth, cooking and housework. They also work on the problem-solving skills needed for managing a home or working.

- **Speech Therapist (ST)**: A speech therapist (or more properly, the speech-language pathologist) helps with speaking, listing, reading and writing problems. In addition, he or she helps patients who have swallowing problems or who have difficulties in thinking and memory. When patients have speaking problems, the speech therapist helps the patient and family develop other ways to "talk" with each other.

**Use this Row When**:
- The person receives therapies from a licensed therapist (PT/OT/ST) at any location. This row is an exception to the rule that HRS tasks recorded must be only those provided in the home.

**Do NOT Use This Row**:
- For exercises done by the person alone or by other caregivers, even if under the instructions of a therapist. Use the "exercises/range of motion" row for those types of circumstances.

**How to Determine the Frequency**: Mark the frequency column which reflects the "combined frequency" of PT/OT/ST.

"Combined frequency" equals the maximum number of sessions per week of therapy services provided. For example: PT/OT/ST once each day, 2 days per week = 6 sessions per week, which converts into 6 days per week on the screen. Record this frequency under the 5+ days/week column on the skilled therapy row.

Use of the Independent column is not applicable for this row.

## 6.28 "Other" Row

**Use this Row When**:
- Recording those health-related services you are unable to capture on any other row of the table. Remember that the use of the table primarily pertains to in-home services.

**Do NOT Use This Row**:
- For unskilled tasks which are captured elsewhere on the screen or as a "notes" section to further describe details about HRS for the person. For example, the use of "TED" (anti-embolism) stockings should be captured under the Dressing ADL, not on the HRS "other" row.

**Tip**: Use of the "other" row will be monitored by the DHFS at regular intervals and cases will be referred to screen leads as necessary for follow-up.

# Module #7: Communication & Cognition

## Objectives

*By the end of this module you should be able to:*

- Accurately complete the Communication, Memory, Cognition for Daily Decision Making, and Physically Resistive to Care questions of the LTC FS
- Describe how the Memory question in this section is different from other areas of the LTC FS that collect cognition information
- Distinguish the difference between a competent person refusing help and a person being "physically resistive to cares"

## 7.1 Four Questions in this Section of the LTC FS

1. Communication
2. Memory
3. Cognition for Daily Decision Making
4. Physically Resistive to Care

***Overview of Communication and Cognition**:*

## 7.2 Face-to-face Contact Required

**The screener must have a face-to-face contact with the person being screened -- in addition to the use of reviewed records and collateral contacts if necessary -- to complete the Communication and Cognition section of the LTC FS.** Medical records including mental status exams may be referred to, if done within the past year, and if still current. Ask health care providers familiar with the person whether such documents are still accurate.

**If the person has serious deficits in cognition and is living alone in the community without significant support, screeners are expected to follow up to assure the person's health and safety.** Such follow up could include an immediate referral to a CMO for urgent services, assistance getting fee-for-service services, or referral to Adult Protective Services or any other prevention/safety programs available.

The categories of Memory and Cognition for Daily Decision-Making do overlap, but the combination helps to clarify needs for diverse populations of LTC consumers. Follow the definitions closely.

## 7.3 Communication

**Communication includes the ability to express oneself in one's own language**, including non-English languages and American Sign Language (ASL) (or other generally recognized non-verbal communication). This includes the use of assistive technology. Assistive technology includes the use of a computer for communication, however, the use of hearing aids would NOT count.

***Communication Options:***

- Can fully communicate with no impairment or only minor impairment
- Can fully communicate with the use of an assistive device
- Can communicate ONLY BASIC needs to others
- No effective communication

EXAMPLES: A person with severe cerebral palsy who is unable to verbally communicate but who can use a computer to communicate all their feelings and ideas in detail “can fully communicate with the use of assistive device.” However, a person with severe mental retardation who is only able to communicate basic needs using a picture/word board “can communicate ONLY BASIC needs to others.”

NOTE: In scoring, this category is not meant to capture all nuances of communication. As a general rule, if a person can’t fully meet a higher functioning category so that communication is efficient, accurate and forthcoming, score them in a lower functioning category.

## 7.4 Memory Loss

Unlike the Alzheimer's Target Group, Diagnosis section, or HRS Table, screeners may be slightly more subjective and use their best professional judgment to complete this Memory question. It is not required that the screener get the verification of a health care provider to complete this question. **Screeners should observe and collect significant evidence to support their judgments for this question.**

***Memory Options (check all that apply):***

- 0 - No memory impairments evident during screening process or unknown or unable to determine
- 1 - Short Term Memory Loss (seems unable to recall things a few minutes later)
- 2 - Unable to remember things over several days or weeks
- 3 - Long Term Memory Loss (sees unable to recall distant past)

Use 0 for people with cognitive or other issues where you are unable to determine.

EXAMPLES: We all forget things from time to time. Some forgetfulness is normal. An older adult who claims they “forget everything” but who are obviously functioning well in their home and community (they still drive safely, monitor their own medications, keep appointments, are active in their church, etc.) may not really have a memory problem. Singular claims by the applicant or their family members need to be supported by screener observations and collateral statements. It should be apparent to the screener that applicant's memory problems are beyond everyday “forgetfulness”.

## 7.5 Cognition for Daily Decision Making

This question is meant to capture **applicant's ability to make daily decisions beyond medications and finances** (both captured in the IADL section).

***Cognition for Daily Decision Making Options (check only one):***

- INDEPENDENT-Person can make decision that are generally consistent with her/his own lifestyle, values, and goals (not necessarily with professionals' values and goals)
- Person can make safe decisions in FAMILIAR/ROUTINE SITUATIONS, but needs some help with decision-making when faced with new tasks or situations
- Person needs help with reminding, planning, or adjusting routine, EVEN WITH FAMILIAR ROUTINE
- Person NEEDS HELP from another person most or all of the time

## 7.6 Resistive to Care

This means **physically resistive due to cognitive deficit**. This question was added because it is an eligibility criterion developed by a LTC Redesign workgroup. It is meant to indicate people who are physically resistive to cares due to a cognitive impairment. There must be an element of cognitive impairment. There does not have to be a legal declaration of incompetence, but there should be some medical diagnosis, or other parts of the screen, indicating cognitive impairment.

> NOTE: You would NOT mark “Yes” to this question if a competent adult refuses services. All competent adults have the right to refuse any services. For each ADL and IADL screeners indicate the help the person needs, whether or not they're receiving it now, and whether or not they accept the help. If the person's refusal for help puts them at risk, you would indicate that in the Risk Module.

# Module #8: Behaviors/Mental Health

## Objectives

*By the end of this module you should be able to:*

- Accurately complete the Wandering, Self-Injurious Behaviors, Offensive or Violent Behavior, Mental Health, and Substance Abuse questions of the LTC FS
- Recognize the difference between behaviors due to cognitive impairment and choices made by a competent person
- Document when a person who is mentally ill needs further mental health services

## 8.1 Five Questions in this Section of the LTC FS

1. Wandering
2. Self-Injurious Behaviors
3. Offensive or Violent Behavior to Others
4. Mental Health Needs
5. Substance Abuse

## 8.2 Overview of the Behaviors/Mental Health Sections

**This module relies on both a history and a structured interview process to accurately record a participant's behavior that may have an effect on the cost of the individual's long term care services.**

"Interventions" in this module includes monitoring and having someone present to prevent a behavior, as well as more direct interventions such as redirecting the person, physically preventing the behavior, and responding to problems caused by the behavior.

*QA Check*: The cumulative amount of behavior interventions documented in this section from the Wandering, Self-Injurious Behaviors, and Offensive and Violent Behavior to Others questions should correlate with the "Interventions related to Behaviors" line of the HRS Table.

## 8.3 Wandering

Defined as a **person with cognitive impairments unsafely leaving residence or immediate area without informing others**. A resident of a facility may not be able to "elope" due to locked doors or exit alarm, but the extent that they "wander" within the facility should be indicated.

***Wandering Options:***

- Does not wander
- Daytime wandering but sleeps nights
- Wanders at night or day and night

*QA Check*: If some wandering is marked here, Interventions related to behaviors should be marked on the HRS Table as well.

## 8.4 Self-Injurious Behaviors

**Behaviors that cause or could cause injury to one's own body.** Examples include physical self-abuse (hitting, biting, head banging, etc.), pica (eating inedible objects), and water intoxication (polydipsia). Self-injurious behaviors are defined as physical self-abuse, not the absence of self-care. In most cases, this question pertains to people with developmental disabilities.

This question is not to be interpreted more broadly. Do not include all behaviors that may have unhealthy consequences, such as smoking, or promiscuity, or eating sugar despite diabetes.

***Self-Injurious Behaviors options:***

- No injurious behaviors demonstrated
- Some self-injurious behaviors require interventions weekly or less
- Self-injurious behaviors require interventions 2 to 6 times per week OR 1 to 2 times per day.
- Self-injurious behaviors require intensive 1-on-1 interventions more than twice each day.

Select the answer that most accurately reflects the frequency of interventions needed for this behavior.

*QA Check*: If some self-injurious behavior is marked here, Interventions related to Behaviors should be marked on the HRS Table as well.

## 8.5 Offensive or Violent Behavior to Others

**Behavior that causes pain or distress to others or interferes with activities.**

***Offensive or Violent Behavior to Others options:***

- No offensive or violent behaviors demonstrated
- Some offensive or violent behaviors which require occasional interventions weekly or less
- Offensive or violent behavior which require interventions 2 to 6 times per week OR 1 to 2 times per day.
- Offensive or violent behaviors that require intensive 1-on-1 interventions more than twice each day.

*QA Check*: If some offensive or violent behaviors are marked here, Interventions related to Behaviors should be marked on the HRS Table as well.

## 8.6 Mental Health and Substance Abuse Questions

**It is estimated that from 40 to 70% of long-term care consumers also have mental health and/or substance abuse issues.**

It is recognized that many people will not divulge this information during the screening process. However, the information is important to share with the LTC program the consumer chooses to enroll in, and for rate-setting and quality assurance. **Screeners should ask about mental health and substance abuse diagnoses when confirming other diagnoses, health-related services, and target group questions.**

**Screeners should also use their professional interviewing skills and observation to elicit the most accurate possible answers to these questions.** Questions from nationally standardized screens such as the “CAGE” questionnaire and other screens for geriatric populations could be used to elicit information to help screeners answer the LTC FS questions.

***Mental Health Needs options:***

- No known diagnosis of mental illness--no mental health problems or needs evident

- No known diagnosis of mental illness-person may be at risk and in need of some services
  - "Person may be at risk and in need of some mental health services" is an opportunity for the screener to indicate their professional judgment that the person may be at risk and in need of some mental health services. Frequent crying, hand wringing, frowning, poor eye contact, flat affect, expressions of despair, self-hate or hopelessness, etc., can all be signs of depression or unresolved grief with which the person may need help. The screener is not diagnosing anything, they are merely indicating that the person "may be at risk and in need of mental health services." Current system problems (such as cultural or funding barriers to access of mental health services) should not prevent the screener from indicating what is perceived in the applicant's demeanor and situation.
- Person has current diagnosis of mental illness that is currently stable
  - "Stable" here means the person is functioning well with routine periodic oversight/support, and is currently receiving such oversight/support
- Person has current diagnosis of mental illness that is currently not stable
  - The person needs intensive mental health services (whether they are currently getting them or not--they need them.)

Simply because a person is prescribed an anti-depressant does not necessarily mean that they are depressed. Anti-depressants are prescribed for other reasons than depression, such as chronic pain. Contact a health care professional to find out what the antidepressant is for. This applies to the diagnosis table as well as the mental health question. Screeners are never to deduce, infer, or otherwise "make up" diagnoses. Always confirm.

Unstable does not equate with CSP enrollment. There are many individuals who receive CSP services who are extremely stable. Indicators of mental health instability are frequent hospitalizations (more than one a year, usually), exacerbations of positive symptoms (hallucinations, delusions) to the point where it interferes with work and disrupts relationships, or a need for frequent adjustments in psychotropic medications. This list is not all-inclusive but are some of the indicators you would want to ask about.

*QA Check*: If mental health needs are identified as a 2 or 3 (current diagnosis), a corresponding diagnosis under H. on the diagnosis page should be checked.

***Substance Abuse Options:***

- No active substance abuse problems evident at this time
- Person or others indicate a current problem, or evidence suggests possibility of a current problem or high likelihood of recurrence without significant on-going support or interventions
- In the past year, the person has had significant problems due to substance abuse. (Examples: police interventions, detox, inpatient treatment, job loss, major life changes.)

The information collected from the mental health and substance abuse questions play no role in the eligibility logic. They are informational for the LTC program enrolled in by the consumer. These questions may be used for quality assurance and improvement studies to see that mental health or substance abuse problems noted in the LTC FS are being addressed by the LTC program in which the consumer enrolls.

# Module #9: Risk

## Objectives

*By the end of this module you should be able to:*

- Accurately complete the Risk section of the LTC FS
- Define “imminent risk of institutionalization” and why it's important
- Make appropriate referrals to APS for persons being screened by the LTC FS
- Identify when Risk Box 2 should be checked based on items checked earlier in the LTC FS

## 9.1 Overview

**The risk section of the LTC FS has been designed to do the following:**

- Identify consumers who may be nursing home eligible due to imminent risk of institutionalization
- Indicate other risk factors to the LTC program if person chooses to enroll
- Family Care: Identify consumers at the Family Care Intermediate level of eligibility who have confirmed need of APS services

Newly discovered cases of abuse and/or neglect should in most instances result in a referral to APS for investigation, case planning and any necessary court related services. This module does not replace the function and process of the APS unit. **Screeners are expected to recognize signs of abuse or neglect and to know how to respond appropriately.**

## 9.2 Part A - Current APS or EAN Client

**The following section applies to Family Care:**

**Persons found eligible for Family Care at the Comprehensive level are eligible and entitled to the Family Care benefit.** “Entitled” means they cannot be put on waiting lists, and their chosen CMO cannot refuse to enroll them.

**Persons found eligible for Family Care at the Intermediate level are not entitled unless they:**

- Have a Medicaid card, or
- Are on the county's “grandfathering” list, or
- “Have a confirmed need for Adult Protective Services (APS)”

**Only APS staff are qualified to determine whether a consumer “has a confirmed need for APS.”** A referral to APS does not constitute a confirmed need for APS. Being a current client of APS does. Resource Centers are to establish good communication links with APS to allow for timely assistance with this issue. If the person is eligible at the Comprehensive level, this issue is not important.

Family Care screeners with APS-related questions should direct these first to their county APS unit or their county corporation counsel. If there are unanswered questions, screeners should ask their designated Screen Lead, who will in turn direct these questions to the CDSD clinical consultant, if necessary.

***A1 - Person is known to be a current client of APS***

This reads “is known to be…” in recognition of the fact that the screener may not know the person is a current APS client, and the consumer being screened may not divulge this information to the screener. Screeners should ask as part of screening if a person is an APS client.

***A2 - Person is currently being served by the lead Elder Abuse and Neglect (EAN) agency***

EAN is separate from APS, and an EAN client may or may not “have a confirmed need of APS.” The screener will ask if the person is a current APS or EAN client. If the person is an EAN client, the screener may contact the local APS unit to determine whether this EAN client “has a confirmed need of APS.”

**Note Family Care**:
You do not have to do this if the consumer appears eligible at the Family Care Comprehensive level of eligibility; the “confirmed need for APS” only matters if the person is eligible at the Intermediate level. When this is the case, screeners should inform the APS unit of this, so they'll respond with their determination as soon as possible. (Meanwhile, screeners can refer the person for financial eligibility processing, etc.)

## 9.3 Part B - Risk Evident During Screening Process

Note that whether the consumer is aware of and chooses a level of risk is irrelevant here. They may well choose to take the risk. But the screener is here indicating that, in her/his professional judgment, there is some risk. The screener then follows up in accord with her/his usual professional judgment.

***0 - No risk factors or evidence of abuse or neglect apparent at this time***

At least one box in Part B must be checked. Check all applicable boxes, however if box “0” is checked, do not check boxes 1, 2 or 3.

***1 - The individual is currently failing or is at high risk of failing to obtain nutrition, self-care, or safety adequate to avoid significant negative health outcomes.***

This is Wisconsin APS language and is essentially informational only. It plays no role in eligibility determination.

***2 - The person is at imminent risk of institutionalization if s/he does not receive needed assistance or person is currently residing in an institution.***

This is federal language specifically intended for person who will be deemed nursing home eligible because they are “at imminent risk of institutionalization if they do not receive the needed assistance.” The federal Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration) advised states that “imminent risk of institutionalization” means that the person “would require nursing facility or ICF-MR care within 6 to 8 weeks if community-based services were not provided.” This level of risk also applies to and should be used for consumers who currently reside in an institutional setting.

**Box 2 is critical in determining the consumer's nursing home eligibility.** Persons not deemed NH eligible from the HRS table-i.e., those who don't have sufficient “skilled nursing” needs-may be deemed NH eligible if the screener checks this box in the Risk section of the LTC FS. Screeners should consider this box carefully and check it if it applies. The risk category applies to:

- Relocations – People who leave an MA funded facility and move to the community.
- Diversions – People residing in the community who are at risk of institutionalization.

Box 2 should be checked for a person with quadriplegia, no matter who is providing help. For instance, the family could be doing the cares. Perhaps he is stable and not on medications and has no skilled nursing tasks; he would, however, be "at imminent risk of institutionalization" if he did not receive help with his ADLs and IADLs. A person with total quadriplegia could die within a few days if he didn't have someone to help him eat and drink, turn over, etc.

**Box 1 and Box 2 often overlap. Box 1 is broader than Box 2**, and can include persons for whom Box 2 does not apply. In other words, the person may be at risk, but the Screener may have no indication that they'd be admitted to a nursing facility within 6 to 8 weeks if they didn't get help.

> Example: Helen is a 90-year-old woman living alone, independent in all ADLs and IADLs, with no obvious cognitive impairment, and no behavioral problems or other symptoms. Yet she is living in a tiny rundown house with 32 cats, filthy conditions, and broken plumbing. She says she eats three meals a day, doesn't' mind the cat hair, cat urine and feces, etc., throughout the house, and doesn't need any help. She has no medical conditions and no health related services at all. Screener should check box 1 to indicate the Helen is "currently failing or at high risk of failing to obtain…" But screener should not check Box 2 because it is not clear that Helen would be eligible for nursing home (let alone at risk of nursing home placement) within 6 to 8 weeks.

***3 - There are statement of or evidence of possible abuse, neglect, self-neglect, or financial exploitation***

If yes:

- Referring to APS and/or EAN now, or
- Not referring at this time, because competent adult refuses to allow referral

Screener can check this box to provide warning to the person's selected LTC program that the person is at risk.

In many instances, the screener would report the case to APS or EAN. However, reporting is left to the professional judgment of the screener, because (1) competent adults can refuse to allow such referrals, and (2) sometimes making the referral would only exacerbate the situation. In the latter case, the screener could ask for advice from APS staff without divulging consumer information and continue to interact with the person.

Use the comment field here to write in the details of what you have heard or observed concerning the risk.

***4 - The person's support network appears to be adequate at this time, but may be fragile in the near future (within next 4 months)***

This box is also only information for the person's selected LTC program.

# Module #10: Completion of the LTC FS

## Objectives

*By the end of this module you should be able to:*

- Accurately complete the time it took to complete a screen
- Utilize the Notes utility built into the LTC FS application
- For Family Care: Identify when a person meets the criteria for grandfathering into Family Care

## 10.1 Grandfathering Question (For Family Care CMO Counties Only)

Screeners in programs other than Family Care need not complete this section and should skip completing this part of the screen. "No" is pre-set as the default answer and will suffice for non-Family Care agencies.

The following section applies to Family Care:

"Is person eligible for grandfathering into Family Care?"

**Grandfathering applies only to an individual's functional eligibility; it does not apply to financial eligibility.** A person who is grandfathered must still meet financial eligibility requirements to be eligible for Family Care. **A person meets the criteria for grandfathering for functional eligibility at any time he/she meets all of the following conditions.** The person:

1. Has a condition that is expected to last at least 90 days or result in death within 12 months.

2. First applies for eligibility for the Family Care benefit within 36 months after the date on which the Family Care benefit is initially available in the person's county of residence.

3. Does not currently meet either the comprehensive or intermediate level of care.

4. Was, on the date Family Care became available in his/her county of residence, either:
    - A resident in a nursing home; or
    - A recipient, under a written plan of care for at least the past 60 days, of services funded under COP, a HCBS waiver, AFCSP, or Community Aids or other county funding if documented under a method prescribed by the Department.

As the following chart indicates, a person is not eligible for grandfathering during any time when he/she meets either comprehensive or intermediate level of care. But if the person's condition improves so that he/she again fails to meet comprehensive or intermediate level of care, he/she once again qualifies to be grandfathered.

| Current Family Care LOC | *Eligible for Medicaid* | *Not Eligible for Medicaid* |
|---|---|---|
| Comprehensive | May not invoke grandfathering | May not invoke grandfathering |
| Intermediate | May not invoke grandfathering | May not invoke grandfathering |
| None | May invoke grandfathering | May invoke grandfathering |

## 10.2 Screen Completion Date

Indicate the date on which all sections of the LTC FS were complete. It may take more than one day to complete all sections (ADL, IADL, HRS table, etc), especially if a screener must wait for information from health care providers. It is acceptable for one person to enter the demographic information (module 1) and for the certified screener to complete the clinical entries (module 2-6). However, all of the screen entry time should be combined and put under the certified screener's name.

When correcting information on a screen, do not change the "screen completion date." Enter the exact time it took to correct or update a screen. If you are simply making changes to the demographics (e.g., change of address), then enter "0". You must re-calculate eligibility after making screen corrections as required in section 10.8.

Note: The screen completion date is the date when all sections were completed by the certified screener, not the date information is entered into the computer.

## 10.3 Face to Face Contact with Person

This is the amount of time the screener spent face-to-face meeting with the consumer. Please round time to the nearest 15 minutes (00, 15, 30, 45).

## 10.4 Collateral Contacts

This is the amount of time the screener spent face-to-face meeting with collateral contacts (family members, friends, health care providers, etc). And/or the amount of time the screener spent on the phone talking with collateral contacts. Please round time to the nearest 15 minutes (00, 15, 30, 45).

## 10.5 Paper Work

This is the amount of time the screener spent doing paperwork and paper research to complete the LTC FS. Phone contact with the consumer should be included in this category. Please round time to the nearest 15 minutes (00, 15, 30, 45).

## 10.6 Travel Time

This is the amount of time the screener spent traveling to and from appointments associated with the gathering of information necessary to complete the LTC FS. Please round time to the nearest 15 minutes (00, 15, 30, 45).

- **Write all times as hours and minutes rounded to the nearest 15 minutes.**
- **The LTC FS application will sum them up for the total time.**

## 10.7 Notes

Throughout all sections of the LTC FS screeners may click on the “Notes” link on the left bar of the screen to enter notes.

- Notes should be dated and initialed by the screener.
- Notes should be concise and provide additional information that the screener thinks would be of value to the LTC program selected by the person being screened.
- Example of appropriate note entry:
  “January 12, 2003:
  “Ms. Washington has many throw rugs on her wooden floors. We spoke briefly about falling, but this should be pursued further. She is able to prepare meals, but is inclined to get by on sweets because it is too much trouble to “cook for one.”
  “--S. Smith, RN

## 10.8 Calculating Eligibility

The act of calculating eligibility is the final step that makes a functional screen ‘complete’. This applies to new screens, or updates to existing screens.

When you enter a new screen, that screen will be considered ‘incomplete’ until eligibility is calculated. If there is no red check mark next to eligibility on the left-hand navigation bar, then the screen is currently ‘incomplete’. You must calculate eligibility to make this screen ‘complete’, which will show up as a red check mark next to eligibility on the left-hand navigation bar.

When you are making a change to an existing screen, there are some times when you must re-calculate eligibility, and some times when re-calculating eligibility is not required.

Any time you change any data which may cause a change in eligibility (i.e., a change to ADLs or IADLs or HRS, etc), you must re-calculate eligibility, even though the LOC scores may not have changed. In addition, any time you make a change to applicant name, applicant SSN, or applicant birth date, eligibility must be re-calculated, even though these data items won’t have any affect on LOC score.

If you change any of the following data, you will not have to re-calculate eligibility:

- Applicant address
- Applicant phone number
- Applicant gender
- County/tribe of residence
- County of responsibility
- Directions
- Screener’s name
- Referral date
- The PAC question (applicable only for Family Care)

How can you tell when you need to re-calculate eligibility? ***Always check for the red check mark next to eligibility on the left-hand navigation bar***. If there is a red check mark, the screen is considered ‘complete’. No red check mark means the screen is considered ‘incomplete’.

## 10.9 COP Level 3 (For Home and Community Based Waiver Counties Only)

**Note: COP Level 3 only applies to Home and Community-Based Waiver Counties and to Resource Center Counties without a Care Management Organization.**

The COP Level 3 page is optional and should be used after the person has been fully screened to test for waiver eligibility.

***Part A - Alzheimer's and related diseases**:*
***1. The person has a physician's written and dated statement that the person has Alzheimer's and/or another qualifying irreversible dementia.***

***2. The person needs personal assistance, supervision and protection, and periodic medical services and consultation with a registered nurse, or periodic observation and consultation for physical, emotional, social or restorative need, but not regular nursing care.***

Alzheimer's disease and other irreversible related dementia describes a degenerative disease of the central nervous system characterized especially by premature senile mental deterioration and also includes any other irreversible deterioration of intellectual faculties with concomitant emotional disturbance resulting from organic brain disorder.

Irreversible dementia diagnoses include:
- Alzheimer's Disease
- Creutzfeld-Jacob Disease
- Friedrich's Ataxia
- Huntington's Disease
- Irreversible Multi-Infarct Disease (DSM III, 290.4x)
- Parkinson's Disease
- Pick's Disease
- Progressive Supranuclear Palsy
- Wilson's Disease

***Part B – Interdivisional Agreement 1.67**:*
***1. The person resided in a nursing home or received CIP II/COP-W services and was referred through Interdivisional Agreement 1.67 in accordance with s. 46.27(6r)(b)(3).***

Applies to individuals for whom a DHFS/Bureau of Quality Assurance nursing home surveyor has issued a 1.67 administrative order to refer the individual to the county for nursing home discharge and alternative living arrangement (or other needed services).

# 10.10 No Active Treatment (NAT) (Family Care CMO Counties Only)

**Note: The NAT page in the LTC FS only applies to Family Care counties with a Care Management Organization.**

To augment your understanding of the text that follows, refer to the NAT page on the paper form and the NAT algorithm in the Appendices at the end of this instruction manual.

"No Active Treatment" (NAT) is a designation given to individuals with a developmental disability who, for either health reasons or because of advanced age, no longer require treatment related to their developmental disability. In addition, a person with a developmental disability such as cerebral palsy but with a normal IQ could be appropriate for a NAT designation.

In order to use Medicaid funds for Family Care (FC) services, the U.S. Center for Medicaid and Medicare Services (CMS), formerly the Health Care Financing Administration (HCFA), has granted Wisconsin two separate home and community-based waivers. One is for frail elders and people with physical disabilities, and one is for people with developmental disabilities. CMS requires that individuals with a developmental disability receive services through the developmental disabilities waiver unless there is documented evidence that active treatment for the developmental disability is not required. This decision would result in a NAT designation for such an individual.

There are limited circumstances in which a NAT designation would be beneficial to a FC consumer. The care planning process in FC is the same for all members, whether they have a developmental disability or not, so any appropriate active treatment would be included no matter which waiver they are in. The only reason to process a NAT designation is related to a difference in the residential services allowable for people enrolled in the FC developmental disabilities waiver, versus people enrolled in the FC elderly/physical disabilities waiver. Residential services for individuals in the FC developmental disabilities waiver must be provided in a setting of 4 or fewer beds (CMOs can obtain a waiver for settings up to 8 beds). For individuals in the FC elderly/physical disabilities waiver, there is no limit on size or type of residential facility.

The county Economic Support (ES) unit must enter the appropriate waiver and level of care on the CARES system to complete the eligibility determination and FC enrollment process. In non-FC counties, the assessment and care planning activities occur before eligibility determination, so the long-term care program has had an opportunity to determine if an individual with developmental disabilities should receive active treatment, or whether he/she should have a NAT designation. In Family Care counties, the CMO does the assessment and care plan after the individual enrolls.

In order for an appropriate waiver to be designated at enrollment, before the CMO has finished the comprehensive assessment and care plan, the initial Long Term Care Functional Screen (LTC FS) will automatically designate the developmental disabilities waiver if the individual has been checked as being in the federal developmental disabilities target group, (regardless of other target groups checked). Similarly, if a diagnosis normally associated with a developmental disability (i.e., cerebral palsy, muscular dystrophy) has been checked, the LTC FS will default to the FC developmental disabilities waiver.

A NAT designation can be entered if the resource center has certain information, or if the CMO comprehensive assessment supports an NAT designation.

The resource center may check the NAT screen if any of the following are true:
- The person has a terminal illness;
- The person has a documented IQ greater than 75 (The RC must give the documentation about IQ level to the CMO); and/or
- The person is ventilator-dependent.

After completing the comprehensive assessment, or at the time of a re-certification or change of condition screen, the CMO may indicate a NAT designation on the LTC FS, or may request the resource center to do so, if:
- The person meets any of the criteria described in the above paragraph;
- The person has physical or mental incapacitation due to advanced age such that his/her needs are similar to a geriatric nursing home resident;
- The person is elderly (over 65) and would no longer benefit from or no longer wants to participate in active treatment for his or her developmental disability; and/or
- The person has severe chronic medical needs requiring skilled nursing care.

Documentation that supports why the person has a NAT designation must be part of the member's record at the CMO. The Department will monitor the appropriateness of NAT designations by including individuals with NAT designations in targeted care plan reviews.

# Appendices

## A. Glossary of Acronyms

| | |
|---|---|
| ADL | Activity of Daily Living |
| AFCSP | Alzheimer's Family Caregiver Support Program |
| AODA | Alcohol and other Drug Abuse |
| APS | Adult Protective Services |
| ASL | American Sign Language |
| BDDS | Bureau of Developmental Disability Services |
| Bi-PAP | Bi-level positive airway pressure |
| BQA | Bureau of Quality Assurance |
| CARES | Client Assistance for Reemployment and Economic Support |
| CBRF | Community Based Residential Facility |
| CIP | Community Integration Program |
| CIS | Community Integration Specialist |
| CMO | Care Management Organization |
| CMS | Centers for Medicare & Medicaid Services (formerly known as HCFA) |
| COP | Community Options Program |
| COPD | Chronic Obstructive Pulmonary Disease |
| C-PAP | Continuous positive airway pressure |
| CSP | Community Support Program |
| DD LOC | Developmental Disability Level of Care |
| DD | Developmental Disability |
| DD1A | Developmental Disability Level person with significant medical problems |
| DD1B | Developmental Disability Level person with significant behavioral problems |
| DD2 | Developmental Disability Level person who needs help with all or most ADLs and IADLs |
| DD3 | Developmental Disability Level person who is more independent with most ADLs and IADLs |
| EAN | Elder Abuse and Neglect |
| ER | Emergency Room |
| ES | Economic Support |
| FC | Family Care |
| FDD | Facilities for Persons with Developmental Disabilities |
| HCBW | Home and Community Based Waiver |
| HCFA | (See CMS) Health Care Financing Administration |
| HRS | Health Related Services |
| IADL | Instrumental Activity of Daily Living |
| ICF | Intermediate Care Facility |

| | |
|---|---|
| ICF-MR | Intermediate Care Facility for the Mentally Retarded |
| IMD | Institute for Mental Disease |
| IPPB | Intermittent Positive Pressure Breathing |
| ISN | Intensive Skilled Nursing |
| IV | Intravenous |
| LOC | Level of Care |
| LTC FS | Long Term Care Functional Screen |
| LTC | Long-Term Care |
| MAPP | Medicaid Purchase Plan |
| MDS | Minimum Data Set |
| NAT | No Active Treatment |
| NH LOC | Nursing Home Level of Care |
| OASIS | Outcome and Assessment Information Set |
| OTC | Over the Counter |
| PAC | Pre-Admission Consultation |
| PACE | Program of All-Inclusive Care for the Elderly |
| PD | Physical Disability |
| PF | Public Funded |
| POA | Power of Attorney |
| POAHC | Power of Attorney for Health Care |
| PP | Private Pay |
| QA | Quality Assurance |
| QMRP | Qualified Mental Retardation Professional |
| RC | Resource Center |
| RCAC | Residential Care Apartment Complex |
| SA | Substance abuse |
| SNF | Skilled Nursing Facility |
| SPMI | Serious and Persistent Mental Illness |
| SS | Social Security |
| SSN | Social Security Number |
| TMG | The Management Group |
| TPN | Total Parenteral Nutrition |
| WI DHFS | Wisconsin Department of Health and Family Services |

# B. "Mark It" – Reminders for Screeners

- **DHFS Screener Resources Web Site** (Paper Form, Diagnoses Cue Sheet, etc.)
  http://dhfs.wisconsin.gov/LTCare/FunctionalScreen

- **LTC FS Application**
  https://www.dwd.state.wi.us/desltc

- **Security or Password Problems?**
  Can't get into the LTC FS application? Forgot your password? Call the DHFS SOS Desk at:

  DHFS SOS Desk
  Tel: 608/266-9198
  Fax: 608/267-2437
  E-mail: soshelp@dhfs.state.wi.us
  Hours: 9:00-11:30 / 12:30-2:30

  If you need help at other times, you may leave a voicemail and someone will return your call. Indicate you need Functional Screen help.

- **Application or Technical Problems?**
  LTC FS application not working correctly? Call the DWD Service desk at:

  DWD Service Desk
  608-266-7252

- **Still need help?**
  Check with your screen lead. A screen lead has been designated for every screening agency/county. Screen leads are THE local resource for information and they also have the login instructions for the screen training course. If your screen lead isn't able to answer your question, he or she will consult with the appropriate staff at the State.

- **Need to take the Web-Based Screener Certification Course?**
  All screeners must pass the screener training course in order to become certified. The on-line course is available from any computer with Internet access.

  Functional Screener training course at: http://mynursingce.son.wisc.edu/portals/celtc

- **Need help registering for the course?**
  Need help registering? Forgotten your password? Quizzes aren't available? Contact the DHFS SOS Desk at 608-266-9198 or e-mail them at SOSHelp@dhfs.state.wi.us

  Indicate that you need help pertaining to the Functional Screen training course.

# C. Decision Trees and Other Screener Tools

**Refer to the unmarked copy for the following tools**:

- Decision Tree for Frail Elders with Co-Morbidities of Mental Illness and/or Substance Abuse
- Guidelines for Defining Physical Disability
- Decision Tree for PD with Co-Morbidities of Mental Illness and/or Substance Abuse
- Decision Tree for Federal Definition of Developmental Disability (DD)
- No Active Treatment (NAT) Algorithm